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The magazine of the Sonoma County Medical Association

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Medical Education

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FEATURE ARTICLES

Medical Education

7 **EDITORIAL**
Learning, Doing, Becoming
Deborah Donlon, MD

9 **EDUCATION IN FAMILY MEDICINE**
Where are we going?
Jeff Haney, MD

11 **KNOWLEDGE, UNDERSTANDING & WISDOM**
Attending Rounds as a Way of Life and Literature
James Gude, MD

13 **PUBLIC HEALTH**
Community Health Education in the Era of Mass Marketing
Lynn Silver Chalfin, MD, MPH

15 **KAISER PERMANENTE SANTA ROSA FAMILY MEDICINE RESIDENCY**
Meeting the Need for Family Physicians
Walt Mills, MD

17 **EMPIRE COLLEGE**
A Dream of Helping Others
Mary Ellen Pastorino, MS Ed

19 **SANTA ROSA COMMUNITY HEALTH CENTERS**
The Santa Rosa Family Nurse Practitioner Residency
Donna Tully, MSW, PA-C

21 **PIPELINE PROGRAMS**
Investing in the Future Faces of Family Medicine
Katya Adachi, MD

24 **LOCAL CONNECTIONS**
Healthcare Programs at Santa Rosa Junior College
Nancy Thomas, RN, MSN, PHN

25 **MEDICAL ARTS**
2 a.m.
Allison Bacon, MD

Table of contents continues on page 2.

Page 21: Future Faces of Family Medicine

Page 34: Get a Horse

Cover: SCMA President Stephen Steady, MD, FACG. Photo by Duncan Garrett.

Sonoma Medicine

DEPARTMENTS

26 **INTERVIEW**
SCMA President Stephen Steady, MD
Steve Osborn

30 **WORKING FOR YOU**
2013–16 SCMA Strategic Plan

33 **COMMUNITY EVENTS**
The Latino Health Forum
Enrique González-Mendez, MD

34 **OUTSIDE THE OFFICE**
Get a Horse
Martin Bauman, MD

36 **MEDICAL ARTS**
Saying Goodbye
Herb Brosbe, MD

38 **LOCAL FRONTIERS**
Volunteering at the Jewish Community Free Clinic
Donna Waldman, MS

39 **SCMA ALLIANCE & FOUNDATION NEWS**
Keeping Schools Safe from Bullying
Lisa Sugarman

40 **CURRENT BOOKS**
Anthromyopia
Brien A. Seeley, MD

42 **PRACTICAL CONCERNS**
Health Reform Heats Up
James Noonan

44 **PATIENT STORIES**
Linda
J. Michael Gospe, MD

39 **CLASSIFIEDS**
43 **NEW MEMBERS**

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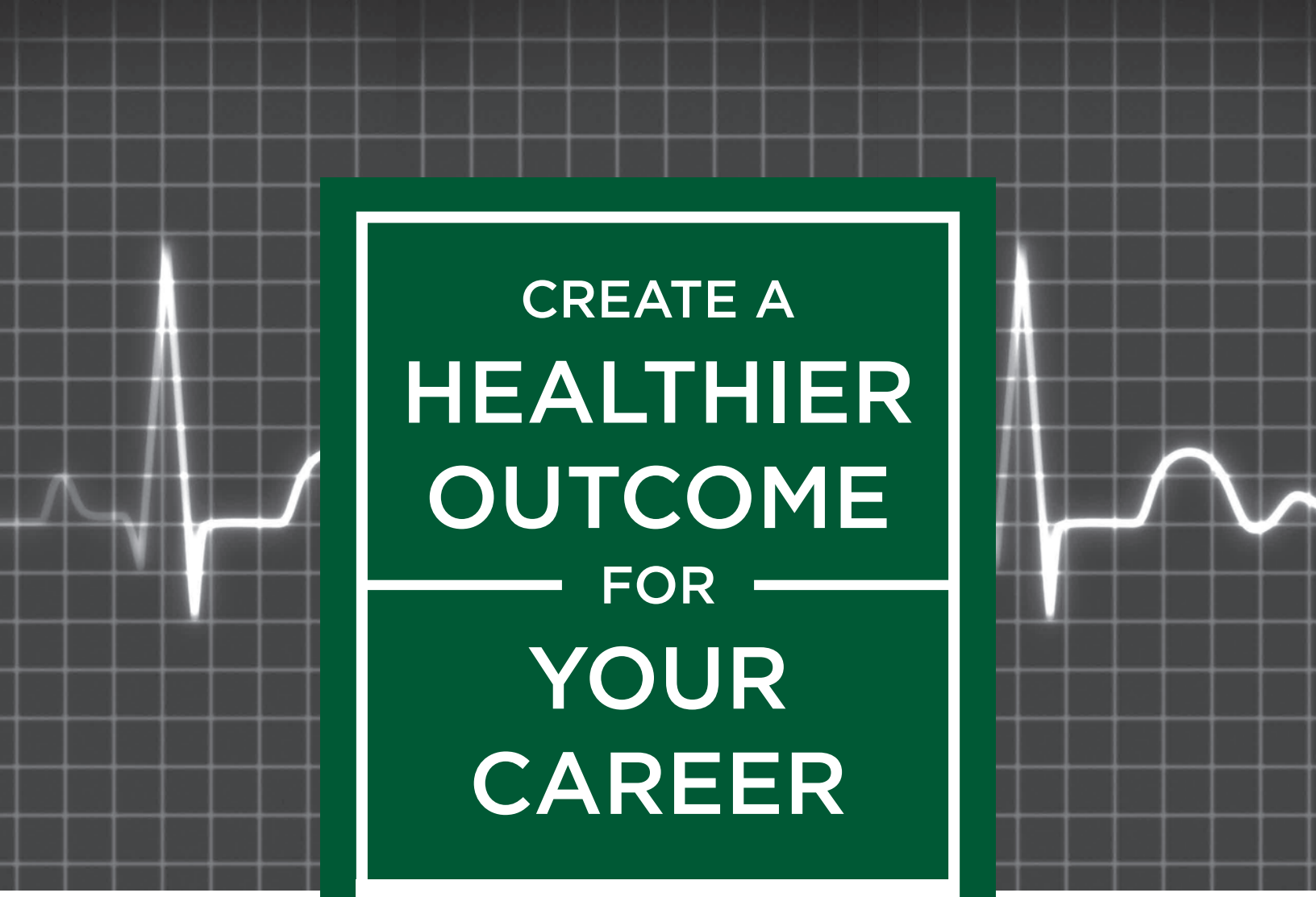

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Learning, Doing, Becoming

Deborah Donlon, MD

At 4 a.m. on a summer morning in 1999, I stood outside the San Diego VA hospital, dressed in scrubs and my short white coat, pockets full of condensed guides to surgery, adult medicine and pharmaceuticals. It was the first day of my third year in medical school. I paused to look up at the building. The only illumination came from the fluorescent glow of hallway lights seeping through the open doors of patient rooms.

The summer morning was warm and pleasant, but I was apprehensive. During the first two years of medical school, I had enjoyed the company of friends and books, but now I stood here alone. I had never scrubbed into cardiothoracic surgeries before, nor taken care of patients in the ICU, but today I was expected to do these things. I briefly wished to be transported somewhere else, where the surroundings were familiar and the stakes were not so high. The road ahead was daunting. Then, some unseen force nudged me through that dimly lit entrance, and the journey to becoming a physician began.

Medical education is a process of crossing over, from an eager, naive student, to a compassionate, knowledgeable caregiver. Our earliest experiences in medical training are some of the most memorable. We know intellectually that people are born and die, but we don't experience these events until we deliver a baby or pronounce a patient deceased for the first time.

Dr. Donlon, a family physician, chairs the SCMA Editorial Board.

We also make mistakes. One of my first tasks on the cardiothoracic surgery service was to draw blood for a patient recovering from an open heart procedure. When his hematocrit came back critically low, my supervising physician realized I had drawn above his IV site, and saved the patient a trip back to the operating room. These experiences are humbling, and they make us grateful to those who teach us and oversee our patient care. We learn, improve and move on to positions of teaching and supervising others.

This issue of *Sonoma Medicine* focuses on medical education. How best to train a physician is a matter of debate. Should the first two years of medical school, typically spent learning facts in a lecture hall and taking tests, be shortened or made more "clinical"? Is "see one, do one, teach one" really the best way to train physicians, or should students spend more time in simulation activities before getting to work with patients? With restrictions on resident work hours, should the length of residency training for each specialty be extended? What incentives could encourage young physicians to work in specialties and areas where there is greatest need?

Here in Sonoma County, we have a storied history as well as a bright future in medical education. The Santa Rosa Family Medicine Residency began as a general practice residency in 1938, switching to family medicine in 1969. The current residency director, Dr. Jeff Haney, discusses where family medicine education is going. One direction is toward Kaiser Permanente of Santa Rosa, which will soon be selecting medical school graduates for its inaugural class of family medicine residents, to begin training in 2015. The director for that residency, Dr. Walt Mills, describes what the new program will mean for our community.

As physicians, we rely on the expertise of our entire medical team. Articles by Donna Tully, Mary Pastorino, Nancy Thomas and Dr. Katya Adachi describe local training programs for nurse practitioners, medical assistants and high school students interested in medical careers. Expanding the scope of our theme, Public Health Officer Dr. Lynn Silver discusses community health education, and Dr. James Gude reflects on the importance of Attending Rounds.

While on a cross-country flight earlier this year, I sat next to a UCSF medical student. After asking about my work, he said, "Santa Rosa . . . I hear you have an attending who plays his guitar during medicine rounds." In a flash, I was transported back to my own residency training, learning the lyrics to Bob Dylan songs from Dr. Rick Flinders. This was one of our first lessons in finding balance as physicians, between the hard work, the caring, the heartache and the optimism.

Isn't it amazing how our medical educators become our community, and central to shaping our identity? We are not just learning and doing; we are becoming. This issue of *Sonoma Medicine* celebrates the journey that is medical education. ◇

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[1]Department of Health and Human Services, National Clearinghouse for Long-Term Care Information, October 2008, www.longtermcare.gov.
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Where are we going?

Jeff Haney, MD

The sun shone on Baltimore's Inner Harbor. The generic hotel conference room brimmed with over a thousand family medicine educators. We sat in a lecture room, listening to a lecture about . . . lectures. In one anecdote, the speaker analyzed the role of the lecture hall in medical school. Is class mandatory? Should classes be streamed? Should they be held in an auditorium? What would you do, as an educator, if only 10% of the class were sitting in front of you, while another 80% were sitting in front of a computer watching you at 1.6 times normal speed? I didn't know we had figured out the optimum rate for listening to human speech, but was reassured that 10% of students still skip class.

I sat baffled and puzzled. Am I really that far removed from medical school? Are we that far behind in residency training? The answer is complex, but in the end doesn't matter. The better question is where are we (family medicine, medical education, the Santa Rosa Family Medicine Residency) going?

Negative Variables

Modern residency training has become more like a mathematical equation, comprised of multiple variables, all determinants in answer to the question posed above. For many years training variables lacked a certain amount of amplitude—not so in the last two years. Our national accrediting body, the Accreditation Council of Graduate Medical Education (ACGME) has tightened the rules and their enforcement: more stringent duty hours, more rigorous evaluation of competency, increased hospital evaluation, rewritten specialty rules and yearly online monitoring. These changes stem from outside organizations holding the ACGME (and its accredited programs) more accountable for its product: competent physicians. The desire for defined quality reaches many levels in the new age of medicine.

Dr. Haney is program director of the Santa Rosa Family Medicine Residency.

Meanwhile, the federal government is in sequestration, scrutinizing the $9 billion it currently spends annually on graduate medical education. Many in the federal government question what the nation gets for that money, and if it should be the federal government that pays the bill. Needless to say, many question whether that funding will continue at current levels and in the same manner.

Furthermore, a well-acknowledged shortage of primary care providers exists in most of our communities. Internal medicine and pediatric residents choose fellowship training over primary care, while graduates of U.S. medical schools continue to apply for family medicine training at disappointingly low rates (about 10%). Student loan debt continues to grow, and the pay inequality between primary care and specialty care continues to widen (specialists currently make double what their primary care counterparts make). Finally, the generation of new medical knowledge changes our understanding daily. Use hormone replacement . . . then no, don't. Use COX-2 inhibitors . . . never mind. Take calcium for bone strength . . . wrong again. Get trained to place Implanon . . . wait, now it's Nexplanon. Use simvastatin 80 mg to prevent that MI . . . on second thought, maybe less is better.

With all the variables that seem to work like negative integers, how do we manage? By considering positive variables!

Positive Variables

The grand opportunity in family medicine and medical education is still ahead of us. Dr. Barbara Starfield's work in the 1990s clearly pointed to the double value of family doctors in a given population: The greater the number of primary care doctors per capita, 1) the healthier the population and 2) the lower the healthcare costs. Her findings were true even in the midst of our haphazard non-system. Imagine what we could achieve if we organized a system actually intended to achieve better results.

Welcome, patient-centered medical home (PCMH). Admittedly, the name makes me die a little inside. (Did we actually talk with patients about what they want?) Consider an alternative: "exceptional family medicine," where our patients get the care they need, in a way that meets their environment and personal story. Care that meets the needs of a community and allows all of

us providing that care the joy of service that brought us to the profession in the first place.

Teaching exceptional family medicine is the challenge that we face. More than anything, graduates will need tools to adapt and lead in a continuously changing medical environment. Breaking it down to smaller components, residents will need to: work in environments that are modeling next generations of care by consistently changing and improving; develop leadership and team-based skills; build a philosophy of lifelong learning and improvement. Our hospitals and clinics must continuously improve, both for the sake of our patients' health, but also as the laboratory for our learners. Residents must be engaged members of the team—working for the common goals of safety, quality, problem solving, efficiency and cost—to be better trained for what comes next.

Much of what has been and will be required of our profession in the years to come is to lead. Very little of the training that has existed in years past has been devoted to leadership. How many of us were provided training to supervise or lead? Conversely, how many of us are in those roles daily?

Finally, we must get better at our work after we graduate. Medicine changes too fast for us to be stagnant. Our profession confuses coaching with "evaluation" and equates effectiveness of a report to performance of patient care. Do any of us have colleagues, mentors or others who watch us do our work, pushing us to get better? Did anyone watch you do your work during residency? Or was it presumed based on your ability to provide the attending with a concise presentation? We need to build an environment of continuous coaching during residency, so that it exists in the environment beyond residency. Habits of continuous learning and improvement must develop in residency so that they continue to be part of daily practice 20 years after graduation.

So, where are we going? Residency programs must train grads to develop leadership skills and the ability to learn through a lifetime of practice that encourages improvement (not just static knowledge attainment). The training must provide a clinical environment that is adaptable and continuously improving.

Seems simple in comparison to "1.6 times normal speed." ◇

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Attending Rounds as a Way of Life and Literature

James Gude, MD

In May 1971, I was visiting Santa Rosa, having drawn a 100-mile radius around Stanford Medical Center while looking for a place to practice and to teach internal and critical-care medicine. As I left Santa Rosa Memorial Hospital, I saw a light across the street. Crossing over, I knocked on the office door of Dr. George Firestone, a clinical professor at UCSF who was leaving his internal medicine practice to become medical director of Community Hospital of Sonoma County.

George invited me into his office, inquiring of my training and intentions. He asked me if I was "any damned good" as a teacher and clinician. I vouched for myself. He asked for a professor at Stanford who would recommend me to be the medical director in charge of ward/ICU medical training of resident physicians at Community Hospital. I suggested Dr. David Rytand. George called David and asked if I were "any damned good." David said yes.

George then offered me an instructorship in family medicine at UCSF; a half-time teaching position running the Community Hospital medical service and ICU; his office for $180/month rent; his personal office practice, including the elite of Santa Rosa, many of whom lived on McDonald Avenue, where I would make house calls; the use of his office charts; and the assistance of his secretary, until I had hired one. He then took me to the Highland House for a steak dinner with an excellent Sonoma County Pinot. I hurried home to Palo Alto that night, relating all to my wife Sally. We moved to Santa Rosa in July 1971, with Leslie, Kate and Bryan, ages 4, 3 and 1.

Dr. Gude, a Sebastopol pulmonologist, has been conducting Attending Rounds in Sonoma County hospitals since 1971.

Shortly after we arrived, a rabbi came to our door, asking why I had not been to the temple, as I had taken over Dr. Firestone's practice; I replied that I was Presbyterian. George and I became great friends and medical colleagues committed to making Community Hospital a Mecca for family physicians. Three months later, George died tragically at age 52 of a dissecting aortic aneurysm. I was on my own. Meeting George had changed my life.

Yale's Dr. Paul Beeson and Stanford's Dr. Fred Eldridge had shown me the power of teaching at the bedside during Attending Rounds. I was soon the Community Hospital attending physician to Drs. Greg Rosa, John Canova, Nancy Davidson and Jim Shubin. They still round with me on most Wednesdays in TeleMedicine Teaching Rounds in the Lew Solomon Teaching Hub at Palm Drive Hospital in Sebastopol. This last Wednesday, May 15, we discussed a case of necrotizing pancreatitis and what is NEW in the management of septic shock following the recent updated guidelines published in *Critical Care Medicine* in February 2013.

We noted that the initial volume repletion recommended has increased to a bolus of 30 ml/kg of normal saline; that a PICC line suffices for CVPs, with fewer line infections; that albumin is back in volume resuscitation if crystalloid is not working; that dopamine is no longer recommended as a vasopressor or renal sparing agent; that norepinephrine is the vasopressor of choice; that epinephrine is the second choice; that vasopressin can be added at a fixed dose to norepinephrine; that steroids are out, save for an Addisonian situation where an IV 200 mg drip daily of hydrocortisone is in; and much more that is NEW—all in the pursuit of understanding and of wisdom.

During rounds, I quoted four literary references pertinent to understanding and learning, which is the goal of teaching anywhere and anytime:

Jesus, Son of Sirach, circa 150 BCE (Ecclesiasticus 51:13-15)
"When I was still a youth, before I went travelling; in my prayers I asked outright for wisdom. Outside the sanctuary I would pray for her, and to the last I shall continue to seek her. From her blossoming to the ripening of her grape my heart has taken its delight in her. My foot has pursued a straight path, I have sought her ever since my youth."

Solomon, circa 1000 BCE (Proverbs 3:13-15)
"Blessed are those who have discovered wisdom, those who have acquired understanding! Gaining her is more rewarding than silver, her yield is more valuable than gold. She is beyond the price of pearls, nothing you could covet is her equal."

Emily Dickinson, 1893

The Brain - is wider than the Sky -
For - put them side by side -
The one the other will contain
With ease - and You - beside -

The Brain is deeper than the sea -
For - hold them - Blue to Blue -
The one the other will absorb -
As Sponges - Buckets - do -

The Brain is just the weight of God -
For - Heft them - Pound for Pound -
And they will differ - if they do -
As Syllable from Sound -

Patch Adams, MD, 1993 (*Gesundheit!*)
"One of the most important tenets of our philosophy is that health is based on happiness—from hugging and clowning around to finding joy in family and friends, satisfaction in work, and ecstasy in nature and the arts."

The latest clinical recommendations based on the best evidence—as found in *NEJM, JAMA, Critical Care Medicine, Up To Date* and your favorite sources AND the reflections on man and woman in Homer, Virgil, the Bible, Dante, Shakespeare, Milton, Tennyson, Whitman, Dickinson and Twain, among others—keep Attending Rounds verdant and vital. I have rounded with Dr. Patch Adams at Sutter Medical Center of Santa Rosa. It was FUN putting on a Big Red Nose and Floppy Shoes and going to the bedsides. One can do the same without the costumes.

Attending Rounds are an opportunity to share vital information with a hearty laugh and broad smile. Attending Rounds are an occasion for serious advice, and for adult fun. The camaraderie of Attending Rounds is one of the solid experiences of medical training. It is the best of an apprenticeship where knowledge, understanding and wisdom are passed on from one generation to another. I appreciate my former medical attendings as I appreciate my parents.

Attending Rounds are like the conversations between Don Quixote and Sancho Panza: many proverbs, much learning, and some wisdom with fun. And the roles frequently reverse! Such was my relationship with Dr. George Firestone, and such has been what I have tried to do with residents and colleagues on Attending Rounds. ◇

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Community Health Education in the Era of Mass Marketing

Lynn Silver Chalfin, MD, MPH

Americans are blasted with sales messages of every ilk, day in and day out. The messages start in pregnancy, as infant formulas are peddled in lieu of breastmilk. Mom and Dad—if they don't live in Sonoma County where our hospitals are getting wise—leave the hospital with a handsome free diaper bag filled with formula bottles all ready for Junior. Junior moves on to infancy and early childhood and is beckoned by ads for candy, sweetened juices, sugar-laden cereals and soda, along with toys and Internet games that keep him from playing in the backyard. By adolescence, he is tempted by tobacco and alcohol ads—not to mention those Cokes on the table at "American Idol." As an adult, Junior is incited to go into debt for a beautiful car rather than using a bicycle or a bus. The onslaught continues into old age, where he is peddled medicines of every flavor rather than gardening, camaraderie or walking.

The common feature of all these ads is that the unhealthiest items are often the most heavily marketed. According to Yale's Rudd Center on Obesity, the situation of advertising to youth may be getting even worse.[1] In 2010, there was a reversal of previous progress in reducing children's exposure to food, beverage and restaurant advertising on television. From 2004 to 2008, exposure had declined by 12%; but in 2010, children viewed 9% more food and beverage advertisements on television compared to 2008—an average of 13.4 television food ads every day. Also in 2010, adolescents saw the incredible average of 16.2 food ads per day, the highest level of exposure seen in the past nine years.

Dr. Silver Chalfin is the Public Health Officer for Sonoma County.

Another recent study analyzed how food advertisements affect the brain by measuring the brain activity of teenagers while watching food and nonfood commercials.[2] Regions of the brain linked to attention, reward and taste were found to be active for all participants, especially when food commercials aired. Overall, the teenagers recalled and liked food commercials better than nonfood commercials.

Despite this growing marketing attack on our children's health, our nation's powerful protections for free speech—originally written to protect political and religious diversity—have been extended by the courts to elevate "commercial speech" to almost the same protected status. While other countries have initiated efforts to control marketing to children, even modest efforts in the United States—such as putting up graphic warning posters on tobacco hazards in stores selling cigarettes—have been blocked in the courts. Efforts by the federal government to create even voluntary guidelines for food marketing to children were also recently blocked.

This massive and unchecked marketing is the challenging backdrop of efforts to educate the population on how to live more healthfully. Financially, we in the medical, dental and public-health communities are vastly outgunned when it comes to educating the public. But that doesn't stop us from trying. Health professionals and public health workers have high credibility with the public. Doctors speaking to patients about tobacco or other issues do make a difference; but in reaching out to people, we are forced to rely on creativity, gumption and shoestring budgets.

Let me focus on a few ways our messages are transmitted. The most powerful method continues to be face-to-face education and support. Even with all our technology, person-to-person contact still has magic, but it can be expensive and difficult to scale up. Many studies of chronic disease have found that the most effective interventions for improving outcomes involve intensive, face-to-face educational efforts.

Other interventions include active medical management combined with education. Nurse- and pharmacist-based interventions have been particularly effective. Kaiser's Preventing Heart Attacks and Strokes Everyday (PHASE) program, for example, has had striking results in reducing cardiovascular risk.

The Diabetes Prevention Program, a national multicenter study begun in the 1990s, reduced the number of people who move from prediabetes to diabetes by 58%, an astounding finding, yet one that has failed to be offered to the population for over a decade and only now is coming into wider use. The YMCA will soon be launching this effort in Sonoma County as part of our Community Transformation program, and the Northern California Center for Well-Being offers similar support for obese adults.

In Sonoma County, the Department of Health Services is implementing the Nurse Family Partnership, in which a nurse accompanies a high-risk new mother from late pregnancy into the child's second year of life with regular educational and supportive visits, as well as shorter intervention models. The program has had highly positive results in improving health, educational and social outcomes for both mother and child.

While usually cost saving in the long run, these programs do cost money to implement, and Public Health and health providers constantly seek other types of interventions.

Telephone contact represents a second, less costly level, but more effective than print. Telephone interventions are widely used nationally for tobacco-cessation support through public "quit lines," and they have proved effective in helping smokers kick the habit. They are also widely used for suicide-prevention and depression hotlines.

Internet, text messaging and social media are in rapid expansion as avenues for community health education, just as they are for commercial advertising. Increasingly, people of all ages receive their information from these avenues rather than, or in addition to, traditional media. They will be used in upcoming Sonoma County campaigns on oral health, sugary drinks and tobacco.

Nevertheless, traditional mass media continues to be an important avenue for community health education. Television, print and radio can get messages across to the public through paid advertising, public service announcements, or other creative involvement. The use of TV tobacco counter-advertising, in which California was a pioneer, has proved highly effective in reducing smoking rates; yet the funds needed to maintain a strong presence of anti-tobacco messaging are scarce. Locally, public TV stations such as KRCB have also played an important role in getting the message out on public health. Sonoma County recently received grant funds to launch media campaigns combining these traditional media with social media.

All these media can work to some extent, from the light touch of a text message to the warm human presence of a nurse by a woman's side. But they all present an ongoing challenge of cost, sustainability and limited capacity to reach large numbers of people. While an ever-increasing amount of society's resources are provided to our medical care system to treat a heart attack or case of diabetes, only very limited funds are available to implement the interventions known to be effective in preventing them. Even then, if the environment provides contrary signals, behavior change is difficult. For example, despite decades of education, and the fact that everyone knows they should eat their fruits and vegetables, fruit and vegetable consumption has been relatively stagnant in the face of the continuing marketing blitz for junk food.

Education for behavior change seems to be most effective when paired with environmental changes that make it easier for people to make the right choice, such as easy access to attractive and reasonably priced produce. After years of education, counteradvertising and significant environmental changes in schools and other settings, sugary drink consumption by children has fallen significantly in California. UCSF researchers recently found that the percent of children aged 2 to 5 consuming a sugar-sweetened beverage the day before decreased from 40% in 2003 to 16% in 2009.[3] Consumption also decreased among children 6 to 10, from 54% in 2003 to 33% in 2009. These numbers represent an encouraging and important shift in our "social norm," likely stimulated by the synergy between community education and environmental change. In previous decades, similar change was engendered by antismoking laws.

In short, community health education is of critical importance, but it is difficult to scale and to maintain. If combined with changes to our environment, community health education becomes more powerful and more likely to result in lasting changes in our social norms and behaviors. ◇

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Meeting the Need for Family Physicians

Walt Mills, MD

Core faculty at the new Kaiser residency, clockwise from upper left: Dr. Walt Mills, Dr. Patricia Hiserote, Dr. C. Roger Turk, Dr. David Koida, Dr. Matt Joseph, Dr. Rachel Friedman, Dr. Cheryl Green, and Dr. Rob Nied. *Photo by Duncan Garrett.*

Why start a family medicine residency at Kaiser Permanente Santa Rosa? The simple answer is that we need more family physicians in our community and beyond. In 2010, the Sonoma County Medical Association partnered with the Department of Health Services to conduct a comprehensive primary care workforce analysis. The results confirmed that our county is facing a crisis in primary care physicians, including family physicians, with an estimated need for an additional 100 to as many as 200 primary care physicians by the end of the decade. Physician retirement, an aging and changing patient demographic, increases in chronic disease, and practice patterns for new graduates combine to make the challenge of sustaining a primary care workforce significant. The impending implementation of the Affordable Care Act relies heavily on a robust foundation of adequate, well-trained primary care physicians. Within this context, the need for more family physicians is abundantly evident.

Kaiser Permanente (KP) is unique in financing graduate medical education through our Community Benefit programs, rather than relying on federal or other funding. In addition to improving the health of our members, KP is committed to improving the health of

Dr. Mills is the program director of the Kaiser Permanente Santa Rosa Family Medicine Residency.

our communities. KP provides care to 30–40% of the population in the Northern California communities it serves, and it has adopted a strategic plan to help meet the needs of those communities by training more family physicians.

There are already six KP family medicine residencies in Southern California, but KP Santa Rosa will be among the first in Northern California (the first is being launched in KP Vallejo in 2014). By the end of the decade, KP hopes to have five family medicine residencies in Northern California. Based on past experience, about 50% of residency graduates stay at KP, and the rest practice in community health centers, local medical groups or other contexts.

Starting a residency is harder than starting a medical school!" So said the CEO for the Accreditation Council of Graduate Medical Education (ACGME) at a recent conference for medical educators. Fortunately, we are well on our way. Our KP Santa Rosa leaders—Kirk Pappas, MD, and Judy Coffey, RN—started planning for the new program more than two years ago. We received our accreditation from the ACGME in January of this year and were notified of our UCSF Medical School affiliation in March. All our faculty will have UCSF clinical teaching appointments.

We have recruited seven core faculty and half a dozen faculty rotation directors in obstetrics, pediatrics and other areas. We're remodeling one of our clinical modules as a model Family Medicine Center for our residents' continuity clinic. Having a teaching module requires some enhancements compared to our usual clinical module, with areas for resident workspace, precepting rooms, video precepting, procedure rooms, and specialty clinics for teaching and care. In the fall of 2014, we'll start interviewing medical students, and our first six residents will arrive for their three years of residency beginning in July 2015. We will recruit six per year until we have a full complement of 18 by 2017.

KP Santa Rosa physicians have been teaching family medicine residents at what is now the Sutter Santa Rosa Family Medicine Residency almost since KP started in Sonoma County 35 years ago. KP will maintain a strong affiliation with the Sutter residency. Dr. Jamie Weinstein, a KP physician, is the deputy program director for the Sutter residency, and three other KP physicians are core faculty. These residents will continue to do rotations at Kaiser. We will collaborate in didactics, conferences and faculty development, as well as other shared resources, such as the Kaiser Simulation Lab.

Our mission is to offer exceptional training for 21st century family physicians in a fully integrated healthcare system with a focus on health promotion, disease prevention and clinical innovations. We are committed to educating outstanding family physicians to provide compassionate care across the life cycle and to improve the health of individual patients, families and the broader community.

In addition to the core competencies in our integrated delivery system, we will provide experience in community medicine, care for the underserved, cultural diversity, global health and a full scope of practice that will allow residents to shape their training through electives. Our resident continuity clinic, for example, is juxtaposed with our Latino Clinic, so that residents will easily be able to gain skills in Latino Health. Residents will also have access to elective rotations at other KP Hospitals in a wide variety of specialty electives.

Residents' access to the high-tech, high-touch practice at KP Santa Rosa fits well with training physicians to practice 21st century medicine. Each resident will have a panel of patients they care for and develop relationships with over their three years of training, using the secure messaging/email system, telemedicine (video visits soon) and virtual care to learn how to best care for patients. We will also have a patient advisory council that includes residents, with a true focus on providing patient- and family-centered care. Residents will provide whole-person care with an integrative, holistic curriculum included in the resident experience. In addition, we have a high-fidelity simulation lab that is unique for community based programs.

The future of family medicine includes an ever-growing appreciation of the importance of community health. Our program will start a Community Medicine Fellowship in 2015, with the Fellow being a dedicated resource for improving systems of care by partnering and learning from our community health providers.

Launching a new program is a challenge. Obstacles include financial constraints, competition with many other priorities, and the difficulty of leading any major cultural change. That said, the Santa Rosa area has a wonderful record of success in medical education and has been a recognized destination for physicians in training for almost a century. The Sutter residency is one of the best in the country, and students nationally know that good things happen in family medicine in Santa Rosa. We are confident that the KP Santa Rosa residency will enhance the quality of training, as well as the actual quantity of family physicians so needed by our community.

The future of healthcare has always been difficult to predict. We are just recovering from the Great Recession, medical schools are under financial stress, and changes are looming with the implementation of health reform. It is still economically challenging for deeply indebted medical students to choose lower-paying primary care residencies. That said, given the alignment with the values and mission of KP and our community partners, the fact that Santa Rosa is already somewhat of a destination for family medicine training, and the tremendous support of our leadership and organization, it's a safe bet that we will succeed. We are convinced it's the right thing for the good of our patients and community, and we are committed to success. ◇

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A Dream of Helping Others

Mary Ellen Pastorino, MS Ed

Graciela Plancarte and fellow Empire College student Ken Killion.

When I started as an instructor at Empire College in Santa Rosa several years ago, I was introduced to the education and training that turns retail clerks, fast-food workers and second-career seekers into medical professionals. I have seen the transformation many times, with many students, but it still impresses me. Offering a medical administrative program since 1969 and a clinical program since 1988, the college has combined a supportive educational environment with a rigorous curriculum. A truly diverse student population has taken advantage of these programs through the years, turning their medical career dreams into a thriving reality.

Graciela Plancarte is one such student. She graduated from Santa Rosa High School and then took a year off to figure out what she really wanted to do. While working at Orange Julius in the Santa Rosa Plaza, she was inspired by her best friend's mom, who had completed the medical assisting program at Empire and loved it. Graciela knew she wanted a career where she could help people. In August 2011, she came to Empire and inquired about starting college. With help from an admissions representative, she decided to enroll in the 18-month degree program in medical assisting. She could have chosen one of the shorter programs, which focus on just front-office administrative skills or back-office clinical skills. By choosing the degree program, she dared to dream of getting both sets of skills and lots of hands-on training in both computer software and patient care.

Almost all medical-assisting students start their first six-week set of classes (called a module) with Medical Terminology and Medical Office Procedures. Melissa Vineyard, RN, the head of Empire's medical department, teaches the beginning medical courses.

Ms. Pastorino is director of education at Empire College in Santa Rosa.

These focus on the language of medicine and introduce students to the many types of medical professionals and their scope of practice.

Medical-assisting students are issued their Empire scrubs once they pass the first medical terminology class. By selecting their scrub uniforms, students celebrate their first successful step in the transformation process. The selection day is a rite of passage, with more experienced student mentors monitoring the mayhem of the new students trying on the various scrub sizes and colors. Graciela says, "I loved getting my uniform. Even my family treated me differently when I came home wearing it."

During the first module, students also take Career Transitions, a class that teaches how successful people think. In this class, Graciela learned the power of dreaming big, setting clear goals, and nurturing positive thoughts while taking on new challenges. At age 20, she learned to take the reins of her own life and steer in the direction she wanted to go. By the start of the second six-week module, wearing new scrubs and focusing on her goals, Graciela was well on her way to becoming a medical assistant.

Shannon Tinsley, the manager of our medical department, had Graciela and other students in her Medical Terminology II class apply for membership in the California Medical Assistants Association (CMAA), the state's organization for medical assistants. This application is one of the many ways that students start connecting with the community. Shannon, herself an Empire graduate, is the driving force behind having students learn by doing, and she managed over 100 student volunteer events last year. There are opportunities for newer students to help with company health fairs, Senior Center outreach and CMAA education days. Students who have earned their injection, venipuncture and phlebotomy certificates can participate in even more volunteer opportunities.

Graciela practiced her new medical skills during the flu shot clinic last November and at various American Heart Association events. She feels the volunteer opportunities really added to the school experience and is especially grateful for the American Heart Association events, where she was able to take blood pressure readings for patients of varying health and ages. She is just one of many students carrying on the well-integrated tradition of community service and giving inspired by Henry Trione, Empire College's founder.

In June 2012, Graciela decided to change from the clinical concentration to the phlebotomy concentration, which gives students 100 hours of basic and advanced phlebotomy and an externship—all of which leads to taking the state licensing exam for level 1 phlebotomy technicians. Graciela could also have chosen a concentration in health information management, which includes classes in electronic health records and advanced billing and coding. Graduates from this concentration are prepared to take a national certifying exam in medical billing and coding.

In addition to the phlebotomy classes, the final stretch of Graciela's transformational growth in skills included coursework in urinalysis, EKGs, capillary puncture, injections, surgical assisting and basic life support. She also took practice tests for the certifying exam offered by the California Certifying Board for Medical Assistants and participated in a project class that helps students transition to a busy medical office.

As Graciela completed her final set of clinical classes in February of this year, her solid GPA and attendance qualified her for an additional opportunity: she was placed in an office to continue her hands-on learning. Graciela was matched with Roseland Pediatrics, a branch of Santa Rosa Community Health Centers, to do 120 hours of externship using her medical assisting and bilingual skills.

The externship helped build Graciela's confidence beyond the classroom. She was working independently as a medical assistant within the first three days after being told it normally takes a week for externs to be working on their own. Graciela is not unique. According to Su Chew, manager at Fountaingrove Cardiology, "The hands-on training that Empire graduates have is very evident, and I have their externs rooming patients on their own the first day of their externship."

Now that Graciela has finished her externship, her final step as a student is near. She is working closely with Empire College's career services department to prepare for her job search. She is polishing her resume and interview skills, knowing she needs to be ready on short notice for a job opportunity. She is also looking forward to that final step as a student, Empire's next graduation ceremony, usually held at the Wells Fargo Center for the Arts.

Graciela will be on stage, in a black gown with a red stole and honor cords, to receive her diploma. She will be another success story. By achieving her dream of helping others, she will launch into a new career. Her transformation to a professional medical assistant will be complete. ◇

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The Santa Rosa Family Nurse Practitioner Residency

Donna Tully, MSW, PA-C

Many creative solutions are currently being funded to address the growing shortage of primary care medical providers in the United States. By some estimates, the nation will experience a shortage of about 45,000 primary care physicians by 2020. The shortage will most acutely impact access to healthcare for already underserved populations, including the elderly, rural residents and diverse ethnic minorities.

Laura McDonald, a graduate of the FNP residency, examines a toddler at Santa Rosa Community Health Centers.

When Americans experienced a doctor shortage in the 1960s, several positive innovations were devised. In 1965, for example, the federal government began subsidizing the training of new doctors in hospital-based residency programs. That same year, two new medical professions emerged: physician assistants (introduced at Duke University by Dr. Eugene Stead) and nurse practitioners (founded in Boulder, Colorado, by nurse Loretta Ford). Today there are over 140,000 active nurse practitioners nationwide, including 18,000 in California alone.

Ms. Tully is the program director of the Family Nurse Practitioner Residency Program at Santa Rosa Community Health Centers.

In 2005, the federal government began responding to a new crisis of inadequate access to primary care medical providers. This time, two main factors were influencing the shortage of healthcare providers: a large cohort of aging baby boomers requiring more medical services, and the fact that fewer medical school graduates were choosing to go into primary care. In 2010, a third factor was added to the burgeoning need for primary care services: passage of the Affordable Care Act, which will bring health insurance to an estimated 30 million Americans, about 40,000 of them in Sonoma County.

How are nurse practitioners helping to address the growing need for access to primary care? In 2007, Margaret Flinter—a nurse practitioner at a federally qualified health center (FQHC) in New Britain, Connecticut—proposed using federal funding to train family nurse practitioner (FNP) graduates for one year in an intensive primary care residency. Her idea spawned eight FNP residencies throughout the United States, including one at the Santa Rosa Community Health Centers, an FQHC in Santa Rosa. Most of these residencies are connected to FQHCs, which are full-spectrum health centers that serve over 20 million Americans, many of whom are low-income and also under- or uninsured.

Flinter recognized the need for more in-depth clinical training for new FNP graduates, especially when dealing with the complex medical, mental and psychosocial issues that most FQHC patients face. The typical FNP training program is at a master's degree level, with an average of two years of post-RN training. Newly graduated FNPs are often faced with exactly the same stressors as family physicians, who have many more years of training: high volume of patients each day, with multiple complex issues and little time to consult with more experienced colleagues. A one-year FNP residency helps tremendously to bolster their training both clinically and didactically, with built-in hours each week for consultation. FNP residents gain more breadth and depth of clinical experience, becoming more confident and competent practitioners and team members.

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Under the Affordable Care Act, the Department of Health and Human Services has allocated $253 million to address the growing primary care needs in this country. Some of that money is being used to subsidize the growing number of FNP residencies. I predict that within the next decade most states will offer postgraduate residencies for FNPs, who will eagerly apply.

The residency program at Santa Rosa Community Health Centers has received inquiries and applications from all over the United States. FNP graduates from Columbia University, Yale, Johns Hopkins, the University of Chicago and several California schools have sent emails throughout the year, hoping to be accepted for one of the 12 residency positions over the current three-year federal grant cycle. Four FNPs have graduated since the residency began in January 2012, and two more are due to graduate in January 2014. Three new residents will begin their year-long training this July.

During their year of residency, the FNPs are precepted by physicians, physician assistants, NPs and RNs for 30-plus hours a week of clinical practice and four to eight hours a week of didactic lectures and case studies. The curriculum emphasizes the cornerstones of primary care: family medicine, outpatient pediatrics, gynecology and internal medicine. By the end of the year, the FNPs are seeing 20 to 22 patients a day, the same as their more seasoned midlevel colleagues.

Some questions remain to be answered about the effect these FNP residencies will have on the future healthcare needs of Americans. Will most or all future FNPs choose a postgraduate clinical residency, or even be required to add a residency to their current NP training programs? Will these residencies be self-sustaining when federal funding ends? Will FNPs with additional training be more likely to become independent healthcare providers or to remain as part of a primary care team? Only time and future studies will tell. ◇

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Investing in the Future Faces of Family Medicine

Katya Adachi, MD

Eager for exposure to nourishing experiences, nine local high school students recently completed Future Faces of Family Medicine, a pipeline program aimed at recruiting underrepresented students into medicine. Just as water from a pipeline helps grapevines thrive in a dry climate, so pipeline programs like FFFM sustain students who must overcome a harsh social environment to thrive in a medical career.

The pathway to becoming a doctor requires years of endurance, focus and flexibility. Having family members or friends who work in medicine can be like holding a key to the front gate; the insight and encouragement they provide can facilitate entry and success. For those who don't have these connections, even considering the journey can feel overwhelming. "High school students who come from underrepresented backgrounds . . . may not otherwise have the role models or the right environment or situation or atmosphere to feel like they could succeed and pursue a career in healthcare," observes Dr. Jimmy Wu, one of the founders of FFFM.

For underrepresented minorities, social inequalities can further heighten the challenges. "I feel like my biggest struggle will always be money," says FFFM participant Gissell Jacome, a senior at Piner High School. "We come from low-income families. My parents, they didn't even finish high school. My mom, she went to elementary school for two years. It's always hard when you have to educate yourself on what to do and where you want to go."

Dr. Adachi and Gisselle Jacome.

This was the inaugural year for FFFM, which was implemented in collaboration with the Health Sciences and Biotechnology Career Pathway offered by Piner High School. This collaboration was essential, as an important element of effective pipeline programs is establishing and sustaining relationships with the local schools.[1] During the four-month program, all nine students—who came from Latino, Cambodian or Eritrean backgrounds—were paired with a resident physician from the Santa Rosa Family Medicine Residency. The students shadowed their mentors in clinic at the Vista Family Health Center, participated in workshops in suturing and physical exams, attended social events, and went through a graduation ceremony to celebrate their accomplishment.

Funded by the California Academy of Family Physicians, Santa Rosa's FFFM was developed by Dr. Wu, a graduate of the residency, and Dr. Mariah Hansen, a staff psychologist with the residency. "When you look at ethnic disparities," says Dr. Wu, "there's a lot of research that talks about racial concordance, which basically means that, for example, an African American patient having an African American doctor actually adds value to that particular experience or visit and actually adds a lot to the healing and the trust." Indeed, studies have shown that racial concordance between patient and provider is associated with better patient satisfaction with the quality of their care, probably due to improved communication and trust gained from language and cultural congruence.[2–4] Yet, minority patients are less likely than white patients to have such concordance with their provider.

Gissell understood the importance of culturally responsive care. "As family doctors, you guys see a lot of culturally diverse people. I feel that given that I'm Mexican and I speak Spanish, I can relate to families that are Mexican. And I know that there are some families that sometimes don't feel as comfortable with some random doctor . . . they can't even communicate because they don't

Dr. Adachi is a third-year resident at the Santa Rosa Family Medicine Residency.

speak the same language." Seeing this need in healthcare motivates Gissell to continue to pursue a career in family medicine: "That helps me realize that I want to help families."

Because minority physicians are more likely to practice in underserved communities and to work in primary care, increasing the cultural and social diversity of medical trainees improves both access to care and experience of care in underserved communities.[5–7] It is insufficient, however, to rely on minority providers to meet the needs of underserved communities, and inaccurate to imply that white physicians would be unable to do so. Thus, training a work force of both minority and white providers skilled in culturally responsive care is paramount to improving population health.

Increased diversity in medical training is requisite for the development of such skills. Through interactions with people of other cultures and backgrounds, trainees gain and practice skills in cultural humility. As noted in a classic *Health Affairs* article, "Health care professionals cannot become culturally competent solely by reading textbooks and listening to lectures. They must be educated in environments that are emblematic of the diverse society they will be called upon to serve. . . . Only by encountering and interacting with individuals from a variety of racial and ethnic backgrounds can students transcend their own viewpoints and see them through the eyes of others."[8] The diversity of ideas that comes with diversity of people enriches the learning environment.[9–10]

Pipeline programs such as FFFM aim to patch the gaps afflicting underrepresented students in the pathway from primary to higher education. Two of the main gaps are lack of necessary academic preparation and ignorance of the application process for medical and other health schools.[11–12] Studies have found that the exposure, encouragement and guidance offered by pipeline programs are important for sustaining interest and ultimately recruiting students into the health fields.[11,13] "We're getting exposed to something that a lot of people don't even know about," says Yessica Moran, one of the students in the Santa Rosa FFFM program. "Working with patients was exciting . . . working with all kinds of patients, that's what I want to do. And actually seeing what a typical day looks like—it's awesome!"

FFFM has the added benefit of fostering an interest in family medicine. Many medical schools unfortunately do not emphasize family medicine as a specialty, despite its being the field with greatest need, particularly in underserved communities. "Towards the middle of the internship," recalls Gissell Jacome, "my mind changed and my goals changed, too. I got more interested in family medicine. . . . They focus on children and moms and dads and grandparents: the whole family and not just one little group. I feel like that fits my personality better." The diversity of patients was appealing, and so was the trust built through the continuity of relationships. As Yessica observed, "[It's] important that someone trusts you that much to come to you for help and that you can actually change someone's life because they trust you."

Being exposed to the process of medical education at the residency was both enlightening and encouraging for the FFFM students. Gissell described how "listening to the residents who are still going through their journey to become a family doctor and how they still ask questions" helped her feel better about all the questions she had and how much she had to learn. "The fact that they still have questions and they still kind of doubt themselves, that reassures me."

Perhaps most important, the relationship between mentors and students helped build confidence. Getting to know a doctor on a personal level demystified the "doctor" role, making the profession feel more attainable. This individual attention and encouragement plays an important role in the success of pipeline programs.[14] As Gissell recalled, "You guys had the confidence in us even though we didn't really see it in ourselves at first, and it just kind of built trust between us and our mentors and all of us together."

The FFFM students' teacher at Piner High School, Judy Barcelon, noticed the changes as well: "They just all come back so mature. They talk professionally. It's really given them a lot of confidence." This confidence early in a student's path to medicine is vital to sustaining interest and is a building block for future success.

Yessica plans to major in biology at Dominican University. After participating in FFFM, she is more aware of the importance of ongoing exposure to medicine, and she plans to seek volunteer opportunities at a local hospital or clinic. She is more confident in her plan to work with the underserved. "I want to go to medical school and become a family doctor," she says. "I want to volunteer in rural areas that lack medical resources, work with my community and give back, and help students who have goals like me."

Gissell plans to attend UC Santa Cruz next year. Although undecided in her major, her desire to become a family doctor is clear. "When I was doing that," she remembers, "I felt professional. I felt like this is what I want to do: I want to be a family doctor." Despite the barriers, Gissell feels motivated to reach her goals: "When you know you want to do something, it doesn't matter what your family says, what the TV says, what anybody says—because if you want to do it, you will do it."

Pipeline programs such as FFFM help pave the way to medical careers for students who might otherwise slip through the cracks. Through personal mentoring, clinical exposure and educational activities, such programs nourish underrepresented students, thereby developing a resource crucial to addressing health disparities.

"A lot of other people who had never heard of family medicine are now [saying] I want to be a family doctor," ob-

serves Yessica. "So now when people ask us what we want to do, there are 10 kids in the corner who want to do family medicine."

These kids are the future of medicine. Their dreams illuminate our hopes for a future face of medicine that brings health equity to everyone in our community. Like a fine wine, that is a future social investment worth the time and energy to develop. ◇

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Healthcare Programs at Santa Rosa Junior College

Nancy Thomas, RN, MSN, PHN

As noted in the recent UCSF report, "California's Health Care Workforce: Readiness for the ACA Era," medical workforce shortages in the state will increase when at least 4 million more residents receive coverage in the coming years through the Affordable Care Act. At Santa Rosa Junior College (SRJC), we are doing our part to train future generations of medical workers in preparation for this shortage. We actively partner with many medical facilities in our community to achieve this training in an environment that promotes success.

Our mission at SRJC has always focused on responding to the community's educational and job-training needs, and we have long been regarded as a leading provider of healthcare education in California. Our current programs teach students to become nurses, medical and dental assistants, community health workers, pharmacy and radiologic technicians, sonographers and phlebotomists.

We accept 120 students a year into our associate degree nursing (ADN) program, and 32 students every 18 months into our licensed vocational nursing (LVN) program. Students in both programs have a very high pass rate on state board exams, as do our medical and dental assisting students. LVN students often find themselves with more than one choice for employment when they finish the program, as our community uses a large number of LVNs.

The radiologic technician and medical assistant programs were both updated and revamped in 2012. The radiology program will be taking 20 students every fall, and the medical assisting programs a total of 50, including 30 clinical students every fall and 20 administrative students every summer.

Our medical sonographers program is offered in conjunction with Foothill College. The program currently accepts five students for each 18-month certificate. Lectures are teleconferenced from Foothill to SRJC, but students must complete clinical and lab requirements at Foothill itself.

We also have a trailer, bought by the Rotary Club, that we use for dental clinics both in the local community and in foreign countries. Under the supervision of our dean, Dr. Ezbon Jen, students and volunteers staff the trailer during its annual trip to Mexico.

SRJC has been providing Medical Assisting healthcare workers for local physicians for several decades, but we can always use more input from the physician community. We invite you to join us for our advisory committee meetings. These happen twice yearly and help us immeasurably with training our students. If you're interested, please contact me at the address below.

As a physician or other health professional, you may wonder what else you can do to help address the looming healthcare workforce shortage. There are many ways to help, either directly or indirectly. Most of our students need financial aid because they have little time to work while enrolled in our intense training programs. Our financial aid and scholarship opportunities are limited, and students are faced with living on a tight budget as they pursue rigorous, full-time training. Contributing toward scholarship funds is a major way to assist our students.

Physicians can also mentor students, volunteer to speak in classrooms, or become involved in our Summer Health Care Institute. We also need physician

Ms. Thomas coordinates the medical assisting program at Santa Rosa Junior College.

offices where we can place students in our administrative medical assisting program every summer for eight weeks so they can get firsthand experience working in the community. We are currently looking for a site where we can place 6 clinical medical assisting students and an instructor in the community. In the past we have only used Kaiser for this and we have decided to branch out into the community. If you have a large enough clinic to manage this, please contact me by email at the address below.

We hope local physicians can help us train the healthcare workers that Sonoma County needs, both now and in the future. To offer your assistance, contact me directly at nthomas@santarosa.edu or 707-522-2816.

We have many excellent programs at SRJC and are anxious to provide the community with the healthcare help they need. We welcome your input.

For more details about our various programs, visit www.santarosa.edu/healthsciences. ◇

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MEDICAL ARTS

2 a.m.

Allison Bacon, MD

Mamas, hold your babies tight
tonight. The devil,
he makes his rounds,
like the good doctor dressed in white.

There's a baby, no first breath
- no never -
cries his mother.

Ghosts we cross;
in the midnight all-souls
hour I float one life to
another. I am mother too
but doctor and his pallid hands
fold in prayer. No why
is given
- God has taken -

Mamas, hold your babies tight
tonight. The devil, he
makes his rounds, like
the good doctor,
dressed in white.

Mother
sees every could or would
be wrong or wonderful,
in luminous eyes, mud fingers:
poet, scientist, madman,
sixteen, flying from pickups,
drugs in gutters,
love and terror
she holds it all in
her belly
she hears every
knock at the door
she sees every could have
been different, always lives on fault lines.

No feet, she felt, at least
last night. I am doctor; I try
but I see only the valves
of his heart are still. Four
chambers, doors ajar.
I say he has
died. I am mother. I cry.

Mamas, hold your babies tight
tonight. The devil,
he makes his rounds like
the good doctor, dressed in white.

In this home and
hospital pain is love's pale twin
the ground, unsteady
she writhes
the womb door open
expelling (aftershocks)
he slips like nothing with bones should
like a puddle
perfect never child
I give him back.

Doctor
hears every should have done
sees every would have been
better, lives every
might have saved.

In this mind ghosts
like this collect and pass
now and then
through endless halls at 2 a.m.
and whisper
- could have been -

Mamas, hold your babies tight tonight.
The devil, he makes his rounds,
just like me.

Dr. Bacon, an alumna of the Santa Rosa Family Medicine Residency, is a family physician at La Familia Medical Center in Santa Fe, New Mexico.

SCMA President Stephen Steady, MD, FACG

Steve Osborn

Gastroenterologist Dr. Stephen Steady was born in Nebraska in 1955 but grew up in Petaluma. Fewer than 20,000 people lived in the town during his childhood, and the community was entirely west of Highway 101. Now he practices in a gleaming modern office building on the east side of the freeway, surrounded by high-tech companies and ever-expanding suburbs.

Dr. Steady majored in food biochemistry at UC Davis and then received a pharmacy degree from Creighton University in his native Nebraska. He moved to San Francisco and worked as a pharmacist at Pacific Presbyterian (now called California Pacific Medical Center) for two years before enrolling in the California College of Podiatric Medicine. Halfway through his training, he decided to become a physician, so he returned to medical school at Creighton, graduating Magna Cum Laude in 1985. He completed both his residency in internal medicine and his fellowship in gastroenterology back in San Francisco at CPMC.

For a decade after completing his fellowship in 1991, Dr. Steady practiced in San Francisco, primarily in the liver transplant program at CPMC. He decided to return to Petaluma in 2001, practicing in an office near Petaluma Valley Hospital for several years before designing and moving into his own endoscopy center and office on North McDowell Boulevard.

Dr. Steady has been married to Jennifer Weissenberger for the past eight years. He has two children from his previous marriage: Corey, a law student at the University of San Francisco, and Alexander, a recent graduate of UC Davis.

Mr. Osborn edits Sonoma Medicine.

Dr. Steady will serve as president of SCMA from July until next June. This interview was conducted at his office on May 12.

How would you characterize the economics of your current medical practice? Are you still in private practice? Are you independent of the hospital chains?

I'm still an independent physician, and I'm part of an independent practice association called Meritage. I have not joined any other type of affiliation at all, and I do not want to become an employee. I would rather be able to function outside of that arena because when physicians become part of a larger organization there may be conflicts they are not even aware of. It also addresses the issue of the values the physicians bring to the patient-physician relationship and the lasting effects of the perception of these values from the patient's and public's perspective.

Therefore, I have my own endoscopy center. We have a lot of Medicare patients—and Blue Cross and Blue Shield—because they are the dominant players in the marketplace. It's like fee-for-service was 20 or 30 years ago, short of one thing: the payments. They just keep being ratcheted downwards.

So how is your practice doing at this point?

It's flourishing. I'm doing very well, so I'm not too concerned at the moment. The bigger driving force is that the primary care doctors are getting taken up by the other models of employment such as Annadel, Sutter and Kaiser. The challenge will be the changing referral patterns that are a consequence of the physicians becoming allied with organizations to which they feel they must refer.

You've been involved with establishing the Meritage network. Could you describe your role in that process?

I serve on the Petaluma Healthcare District Board, and Dr. Bob Ostroff and I thought it would be best to bring some of the players to the table and try to talk about the elephants in the room. With the way healthcare economics was starting to swing, we had to figure out what the hospital system was going to be like.

There are a lot of district hospitals within this area, and the model for these hospitals to make money has completely changed as bundled care approaches—it's not trying to fill the beds any more but controlling cost. The question then becomes can we adapt and figure out what we can do with the district hospitals? Why can't we implement what's called a "hub and spoke" concept, where you have a separate medical service organization, and everybody could be part of that MSO and decide where the patients could flow?

For instance, hospitals are experiencing lower patient admissions and cash-flow issues. If they become "centers of excellence" in areas where they excel as part of a larger organization with other hospitals of excellence in other areas, there could be enhanced revenue.

At the moment, Meritage is just a

Dr. Steady in his Petaluma office. *Photo by Duncan Garrett.*

repository of physicians who are able to negotiate, which is good—but they also have the ability to become their own accountable care organization. Most of us don't really know what an ACO is and how it is going to unfold, but over the next three years ACOs will have the ability to take risks across the spectrum of their Medicare patients.

Where do you think the ACOs are going?
My concern is that Obama wants the hospitals to take control of these ACOs. The unions that hospital employees are part of will stay attached to the hospitals, and Obama will appear to the public sector to be maintaining jobs. However, most of the dollars would be going to go to the hospitals, and if they are going to take the majority of the money they may give very little back to the physicians who are really the ones driving healthcare decisions. In my opinion, physicians should control the ACO and the dollars to spend.

Is the Meritage ACO a physician-controlled ACO?
Yes.

What is the participation of the hospitals? Is there any kind of shared risk?
There will be some shared risk, but the hospitals will have to open up their data to be able to follow the patients through the course of that hospital stay. If they don't open up the data, then we aren't going to know how well the patients are cared for during their hospital stay. In order for hospitals to share in risk, they have to be complete partners, and their model has to change.

Are you optimistic that something can be worked out with the Meritage ACO and the hospitals that you're dealing with?
I'm optimistic a relationship can be worked out technically, but there are also competing entities with which to contend. St. Joseph's certainly is trying to figure out how to do their own ACO. If they get a large enough group of doctors in Annadel, for instance, then they can turn around and just say that they have their own ACO. Then that leaves isolated entities such as Sutter and Kaiser with which to contend.

One thing we hear about repeatedly is the lack of access to specialists under the current system. How do you think access could be improved to your services?
I think access could and would be improved if Medi-Cal and Partnership HealthPlan were willing to contract with independent ambulatory surgery centers and endocenters, as opposed to the hospitals. Up to now they have not been receptive, but they seem to be warming up to the idea. I think they pay the hospital close to Medicare rates as it is. They could easily pay the ASCs and endocenters Medicare rates in a bundled fashion, and specialists would take care of these patients, resulting in greater access for them.

We hear more and more about the single-payer system, and there is a very active single-payer group locally. They characterize single payer as Medicare for everybody. What is your view of that effort?
I think if that effort is going to go forward, it can't be run by the government. If you take it away from the government, you have to then take it away from the insurance plans. The insurance plans take 30% of the premium dollar as it is, and they are public companies. So they are actually trying to make money for their stockholders.

If you create a private firm that takes all of the money from Medicare and from the payments of individuals and businesses for healthcare and eliminate the middlemen, insurance companies, then I think single payer would be a very plausible plan. The 30% saving from the elimination of the insurance companies would make this plan financially viable. But that's not going to happen, because of the way the government has politically involved the insurance companies at the start of healthcare reform.

Getting away from the economics, what are your interests within gastroenterology?
I really like liver disease, I am very adept at that. I like doing the procedures. I enjoy taking care of patients who need procedures. That is why I built my own endo center. I also care for liver-transplant patients in San Francisco. Every year I go one or two weeks and take care of the liver transplant service.

So here you're able to do colonoscopies and all of those sort of GI procedures independently of the hospital? Do you need to go over to Petaluma Valley to do any of the procedures?
I still do procedures in hospitals if the endocenter does not have a contract with the insurance company or the patient has complex medical problems. I also take call for the hospital, so I have to do procedures when somebody comes into the emergency room having a food bolus stuck in their esophagus, or a GI bleeder, or other things of that nature.

But if you had to put a percentage, how many of the procedures do you do here in your own office?
At least 90% here. The trend for the last 15 years across the country is that GI physicians have had their own centers. More care needs to be shifting to the outpatient centers.

As a gastroenterologist, do you get many referrals related to obesity?
I do.

What is your view of the obesity epidemic?
Let me give you a perspective from a hepatology standpoint. When I first participated in the liver transplant program, alcohol was one of the reasons for liver disease and cirrhosis and the number one indication for transplant, and then it became Hepatitis C. Now it is what's called nonalcoholic fatty liver disease (NAFLD)—individuals who have fat in their liver and are actually mounting an immunological response and creating scar tissue. NAFLD is now the number one indication for a liver transplant.

Do you feel like there is anything you can do about this?
When patients come to me with elevated liver tests the only thing I can do is tell them that they have to lose 10–20% of their body weight to decrease the concern for liver disease. Sometimes that really hits home. Or I offer a liver biopsy in order to make sure they understand that they may have a problem. But the treatment is the same: it is losing weight or taking vitamin E.

If patients have abnormal liver tests and they hear the story, a lot of them are pretty motivated, particularly the older ones. It is the younger kids who don't believe they are having a problem because their youth colors their perception of their mortality. The lessons learned start at home, teaching children how to cook and make wise food choices.

In your view, what is the role of medical associations such as SCMA and CMA in the healthcare system?
My feeling is that the role should be to function as a unified voice since a strong union is unlikely. We need a voice to say that we, as physicians, believe that healthcare should go forward in a certain way, whether we take on the topic of economics, better health or obesity. I think we need to start picking important points because, otherwise, we are just going to get rolled over economically. If we don't do something, then I think we will become part of a larger system where we have no control and few personal choices.

How is it possible to become a unified voice when you have such a diverse array of voices in the physician community? You're all quite independent.
There is a conflict in Sonoma County because there are physicians who are part of Sutter, Annadel or Kaiser, and then there are the independent physicians. Each of us has a different motivation in how we want things to go. If you are set up in a model where you're employed, you may not have the feeling that you need to make any change since it can be described as a system problem. But if you're not in that employee model, then you have a sense of urgency to do something. And that is why it is so difficult to get physicians motivated to act on the major issues facing our profession.

Do you have any particular plans for your year as president of SCMA?
I'm going to try to tease out why we are in these little enclaves and ask directly what everybody believes in, and what they want to see. What can we do with this economic model, even if you are in the employee model? If you had a choice, would you be in the employee model? Should we create a whole other structure? For instance, if a company comes in and creates a medical service organization that allows you to practice exactly the way you want to practice and gives you an opportunity to share in the risk, would you still be an em-

ployee physician? Those are the kinds of questions that I need to find out from the physician community.

How did you get interested in the business of medicine? You seem to have an acute understanding of the economics of the system.

I am not sure how I embraced the business aspects of medicine, but I think what occurred was that when I went to pharmacy school, I was at the tail end of creating a business as a pharmacist, because that's when mom-and-pop shops were still around. During my pharmacy education, they taught you a lot about business to be able to figure out how to run your store. Not only was it the pharmaceutical side of things, but you also had to know how you did your ledger, where you did your loss leaders, what other products were you going to sell, which ones ran faster, and so forth.

I think medicine is, unfortunately, very complex in its business dealings, and it is not going to change very quickly; but at the same time there are a lot of dollars that are left on the table for physicians in negotiating some of these risk contracts. But they don't know that, because the insurance companies aren't letting them know that. In order to take those dollars and share them among physicians, the physicians need to feel comfortable having big-data people take their data, and parse it, and say, "This is what the data is saying."

For instance, guidelines are guidelines, but the parsing of the data may show the guideline needs to be modified.

What I am trying to do is to show physicians to not be afraid of this change. Don't be afraid of being able to follow your ability to take care of your patient with data, as long as we have control of the data. If someone else gets control of it, then they can use it any way they want, against you. And they do. That is what I am trying to get physicians to understand. ◇

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Sonoma County Medical Association

To All Sonoma County Physicians:

The Sonoma County Medical Association has worked for more than 150 years to address the challenges facing local physicians and their patients. SCMA owes its success to setting and resetting goals relevant to the ever-changing healthcare environment, and to the many physicians throughout the years who have provided effective leadership.

Last December, the SCMA Board of Directors initiated a strategic planning effort and launched an extensive survey to solicit input from all practicing Sonoma County physicians. We also sought guidance from other healthcare organizations, public health agencies and nonprofits. More than 180 people completed the 16-question survey, representing a 16% response rate. In addition to distributing the survey, the SCMA board hosted a meeting in February with the CEOs of local healthcare organizations about how SCMA could collaboratively improve local healthcare.

At a March retreat, the SCMA board used the results of the survey and the CEO meeting to create a new mission, vision and values for SCMA, along with five key strategies. Nineteen physicians subsequently participated in four task forces to identify goals and actions for accomplishing the strategies.

The resulting Strategic Plan, approved by the SCMA board on May 21, provides guidance to our work over the next three years. The plan focuses on how we will serve our membership and have the greatest positive impact on our community. The plan also lays out our priorities and aligns our activities so we can measure our success along the way.

The top priorities will be to help physicians lead change toward new patient-centered, physician-led models of care, and to promote a healthy medical community. SCMA will also continue its commitment to developing physician leadership and organizational efficiencies for a successful and sustainable future.

SCMA is fortunate to benefit from physician participation and from collaborative opportunities with other organizations. We would like to thank these physicians and organizations for their contributions to our new Strategic Plan. We believe their efforts will be rewarded with a more cohesive and relevant SCMA.

Cordially,

Stephen Steady, MD, FACG
SCMA President

Walt Mills, MD
SCMA Past President

WORKING FOR YOU

2013–16 SCMA Strategic Plan

Mission

To enhance the health of our communities and promote the practice of medicine by advocating for quality, ethical healthcare, strong physician-patient relationships, and for personal and professional well-being for physicians.

Vision

Leading Sonoma County into better health

Values

- Advocacy
- Collaboration
- Integrity
- Quality
- Well-Being

Strategies and Goals

LEAD CHANGE IN HEALTHCARE SYSTEM DELIVERY

- Support Affordable Care Act implementation outreach and enrollment efforts to support universal access and create a culture of coverage
- Advance legislative advocacy for physician and patient-physician issues
- Support access to needed care and services

PROMOTE A HEALTHY COMMUNITY

- Reduce obesity in our community
- Improve oral health of our community

ADVOCATE FOR PHYSICIAN PRACTICE VIABILITY AND PHYSICIAN WELLNESS

- Improve physician practice viability
- Promote healthy lifestyle for physicians

INCREASE MEMBERSHIP 5% EACH YEAR

- Promote awareness of membership value
- Target membership retention and recruitment campaigns
- Encourage physicians to practice in Sonoma County

STRENGTHEN SCMA ORGANIZATIONAL EFFECTIVENESS AND EFFICIENCY

- Develop physician leadership
- Refine SCMA governance

Strategic Plan Goals and Related Actions

SUPPORT AFFORDABLE CARE ACT IMPLEMENTATION OUTREACH AND ENROLLMENT EFFORTS TO SUPPORT UNIVERSAL ACCESS AND CREATE A CULTURE OF COVERAGE.

- Optimize efforts to educate physicians and their patients about the impact of the Affordable Care Act
- Support efforts to enroll patients in insurance plans with our community partners
- Partner with existing safety net programs and organizations

ADVANCE LEGISLATIVE ADVOCACY FOR PHYSICIAN AND PATIENT-PHYSICIAN ISSUES.

- Build and strengthen relations with legislators
- Educate physicians about our advocacy role and opportunities for participation
- Support efforts to fix the Sustainable Growth Rate (SGR) and Geographic Practice Cost Index (GPCI) for Locality 99 and oppose reimbursement rate cuts
- Actively build and strengthen our influence and participation in California Medical Association

SUPPORT ACCESS TO NEEDED CARE AND SERVICES

- Promote access to specialty care
- Promote access to mental health services
- Lead efforts to educate medical and general community on palliative and end-of-life care

REDUCE OBESITY IN OUR COMMUNITY

- Advocate for improved community design to encourage safe walking, cycling and other physical activity
- Increase adoption of evidence-based healthy weight interventions in medical practices
- Identify and explore partnerships with local organizations and programs
- Educate about decreasing sweetened beverage intake

IMPROVE ORAL HEALTH OF OUR COMMUNITY

- Promote fluoridation in water supply

IMPROVE PHYSICIAN PRACTICE VIABILITY

- Survey physicians regarding what practice support resources they are interested in or need
- Create action plan based on survey results
- Identify and inform physicians of available practice support resources

PROMOTE HEALTHY LIFESTYLE FOR PHYSICIANS

- Promote physician well-being resources
- Promote awareness of self-reporting and healthy lifestyle programs
- Promote social events for physician

PROMOTE AWARENESS OF MEMBERSHIP VALUE

- Develop communications plan to increase physician awareness of SCMA/CMA
- Identify and define “return on investment” value and benefits of membership for targeted retention and recruitment campaigns
- Promote value of participation in professional organized medicine
- Encourage physicians to participate and represent practicing physicians at the California Medical Association and the CMA House of Delegates

TARGET MEMBERSHIP RETENTION AND RECRUITMENT CAMPAIGNS

- Communicate ”return on investment” value, benefits of membership and successes
- Explore innovative dues structures and payment options
- Design and implement targeted recruitment campaigns
- Expand resident and medical student involvement
- Establish systems for engaging and orienting new physicians

ENCOURAGE PHYSICIANS TO PRACTICE IN SONOMA COUNTY

- Develop expertise to support physician recruitment
- Support physician integration into the medical community
- Partner with county economic boards, Building Economic Success Together, and healthcare foundations

DEVELOP PHYSICIAN LEADERSHIP

- Expand the offering of leadership coaching and training opportunities for officers and board of directors
- Expand opportunities for new leadership to attend the CMA House of Delegates
- Utilize the executive committee to identify and develop leadership in preparation for advancement

REFINE SCMA GOVERNANCE

- Review bylaws to consider membership’s geographic and mode-of-practice representation on the board of directors
- Evaluate and strengthen SCMA policies approved by the board of directors
- Annually review the need to appoint/reappoint committees and their commission of work statements
- Review benefits and efficiencies achieved from shared administration with the Marin Medical Society and the Mendocino-Lake County Medical Society

The Latino Health Forum

Enrique González-Mendez, MD

The Latino Health Forum began 22 years ago, when a group of residents and faculty at the Santa Family Medicine Residency, together with local Public Health officials, organized a small Saturday conference in the Vesalius Room at Community Hospital (now Sutter Medical Center). Approximately 50 people from the local health, human services and education communities gathered at that first conference to learn more about the health needs of Latino patients, as well as the challenges that physicians face in providing care to this underserved population.

When we organized that first Forum in 1991, Latinos made up about 11% of the Sonoma County population. Since then, the Latino population has more than doubled, and about 25% of county residents are now Latino. The Forum has also grown tremendously over these years, developing into a rich and vibrant resource that brings together hundreds of professionals and agencies, as well as community-based organizations.

These individuals and agencies gather to hear from leading experts and to share resources and knowledge. Their goal is to improve Latino healthcare and the social determinants impacting the health of local Latinos. Last year alone, we had 360 attendees at the Forum. Our keynote speakers included Robert Garcia, director of City Project and winner of the American Public Health Association's President's Award; Dr. Francisco González, associate professor of Latin American Studies at Johns Hopkins; and Herb Schultz, director of U.S. Health and Human Services Region IX. In addition, the conference provided multiple presentations by local experts on Latino health issues and programs.

Dr. González-Mendez, faculty at the Santa Rosa Family Medicine Residency, chairs the Latino Health Forum Planning Committee.

A key component of the Forum has been the inclusion of local students. This inclusion grew out of the residency program's partnership with the Santa Rosa Junior College Puente Project, an award-winning program that helps prepare thousands of students for success in university studies. The project's mission is to increase the number of educationally underserved students who earn college degrees and return to the community as mentors and leaders to future generations. I have been privileged to be a mentor with the Puente program for over 15 years.

Several years ago, we provided scholarships for a small group of Puente students to attend the Forum. This experience allowed several of these predominantly Latino students to see for the first time in their lives the possibility of pursuing a medical career. Based on that success, we expanded the scholarships: last year, 90 low-income high school, junior college and university students participated in the Forum thanks to the scholarship program.

The Forum is a significant resource for our community. It has strengthened the knowledge, expertise and collaboration of the many individuals and organizations that are dedicated to improving the health of local Latinos and our community as a whole. Our success would not be possible without the ongoing commitment of the residency program, and of our organizing committee and generous funders, including the Sonoma County Department of Health Services, Sutter Medical Center of Santa Rosa, St. Joseph Health Care System, and Kaiser Permanente.

This year's Latino Health Forum—scheduled for Thursday, Oct. 10—will focus on the health impacts of immigration and healthcare reform. Our speakers include Gil Ojeda, director of the California Program on Access to Care at UC Berkeley, and Xochitl Castaneda, director of the Health Initiative of the Americas, as well as other local and state experts on Latino health issues. We hope you will join us. ◇

To make a donation to the Latino Health Forum Local Student Scholarship, contact Wanda Tapia at 707-953-8532 or latinohealthforum@gmail.com. To register for the Forum, visit www.latinohealthforum.org.

Get a Horse

Martin Bauman, MD

If you like the mountains but have gradually moved away from the joys of lugging a 40–50 pound backpack over mountain passes and switchbacks, there is a solution. After 25 years of backpacking into the Sierras, paying my dues over many trails and trailheads, I decided to start packing gear in on horseback. I once looked at horses as "not for me," but during the last 15 years, I've let the horse do the work, and age has assisted me in revising my thinking on the matter.

While hiking lets you see a varied and vast swatch of land, it's not an experience "in the mountains" but rather "going through the mountains." I never stayed long enough while backpacking to experience the solitude and the changing landscape of light throughout the day. When I arrived at camp, my first thought was about getting to the next destination. When I use a horse, however, I am able to stay at a campsite for five or six days and really find myself in the mountains. I've traveled this way once or twice yearly with friends and family, but mostly by myself. When alone, I am rooted to the mountains in a way I had not experienced while backpacking through mountain trails.

I ride up and back with a wrangler, a skilled rider who leads a few mules or horses loaded with gear, and another one with me perched atop. For a city boy, hanging out with a large beast is not an everyday event. There are a bevy of lessons to be learned in horsemanship and riding. The horses don't pay attention to anything you say because they have been over the trail many times with a variety of "riders." The only caveat I've been told is to make sure the horse knows you're riding and that you're "The Boss." This point is tested immediately by the horse's attempt to eat the flowers and grasses along the trail. When this happens, you must yank his head up and keep him from noshing.

Having a back problem is not a prerequisite for horse riding, though it might be afterwards. Bart Cranny, an ancient wrangler, gave me a back-saving tip: "Swing your hips with the horse like you might do in other more pleasurable evening activities." He also revealed that "Real cowboys wear silk panty hose" to prevent chaffing while riding on a horse. Thanks to Bart, I also understand what "horse sense" means. A horse with 30 extra pounds on its back just munches away at the feedbag until you remove more than he can carry. In contrast, a person just keeps lugging more, lifts weights and says "I can do it" until collapse time arrives.

The wrangler drops you off and then returns a few days later. If you want to have company, the wrangler can stay the whole trip and cook meals. You can bring all the food you want, from steaks to fresh vegetables—whatever your pocketbook can handle. Mountaineers who desire creature comforts can also bring their favorite folding chair.

After achieving my destination, I usually set up a tent and collapse for about 12–14 hours. Most of the time without rain you can sleep under the stars, but "bear canisters" are a must. These devices keep out bears and other critters (mostly ground squirrels and chipmunks) who may come around looking for food. If you go to a place frequented by people, there may be bears, but in over 40 years I have only had one bear encounter.

Most folks frequenting the mountains have a bear encounter story, but I was denied that pleasure until last summer, when a large black bear charged unannounced into my camp, interrupting lunch. I moved away rapidly, but the bear just charged through the camp and continued on his way, bulking up on gooseberries for the long winter. He didn't even touch my salami and cheese.

Once you're settled into your site, the rest is up to you. I won't rhapsodize on the pleasures and beauty of the mountains, as others have already done a far better job, e.g., John Muir, Bill Bryson, Colin Fletcher, Rick Flinders and Cheryl Strayed. Camping near streams and lakes and taking multiple trips for water embeds a remembered path in your mind. After a while, your camp becomes as familiar as your home. The light and shadows are constantly shifting, but the trees and boulders are solidly in place. You soon find your favorite spot or vista for sleeping, reading

Dr. Bauman is a Santa Rosa psychiatrist.

From a horse in the Hoover Wilderness, Eastern Sierra. *Photo by Dr. Bauman.*

or cogitating. The small becomes large as you stay in one place and absorb the mountains. New landscapes and vistas gradually appear as you take short walks without a pack in the vicinity of your camp.

Getting used to the slower, less frantic pace takes a few days. The time in the mountains brings a welcome change from the pressures of the peopled life we live, and it has the added benefit of clearing out the bilge chambers of our computerized existence. "Digital dust" can cloud your eyes and soul.

Hiking without a pack also brings a welcome sense of freedom and connection with the land. I used to navigate with a map, but last year I used a GPS and left "breadcrumbs" at the trail junctures as I hiked through fairly dense red fir and white pine forest. It was a cloudy grey day, and I thought I knew where I was going, but I suddenly got turned around, and each way looked the same. Luckily I checked my GPS and in no time was back on track. That trip wound up with two days of unusual rain and an added hailstorm, but with a good tent and raingear it was fine.

One activity I enjoy is "meandering," which means hiking around without a destination until you're tired, then napping under a tree. I often take lunch, water and a book and hike a long loop or cross-country trip from dawn to dusk. It's nice to know there's a warm sleeping bag and food with no camp to set up. Hardly ever see a soul. I am careful when alone and take few risks because no one will get me out of a jam. I learned that lesson a few years ago, when I hiked up the Dusy Basin below Mount Humphreys and stayed too long because I wanted to catch the sunset. I ended up sleeping amid the rocks in a crevasse, wrapping myself in bags and extra jackets, but still freezing my ass off at 11,000 feet. It was, as one could say, a memorable experience.

For a city slicker born and raised in upper Manhattan, horse packing is the last thing I would have imagined experiencing or writing about. On the way back from camp, I usually have visions of apple pie and a milkshake and the delights of home. The horse also has visions of home. In the last few hundred yards to the barn, even the oldest steed will start to gallop for the familiar. Hold on tight! ◇

Email: tinbaum@sonic.net

If you want more information on horse packing, call me at 707-544-6022.

Saying Goodbye

Herb Brosbe, MD

I am on the deck watching my father. He is so happy. The backyard is filled with a gathering of family and friends. He walks slowly, watching and admiring his four grown grandchildren. He loves them so much. You can tell that from the look on his face.

I slowly walk up to him. "Dad, you don't belong here anymore." He looks very puzzled. "You can't be here," I repeat. His expression says "Why?" "Because you died," I answer. "You do not belong here anymore."

I am crying. I never knew you could cry in your sleep. I am awake now. I feel absolutely horrible.

In reality the whole passage did not take very long. My dad became very frail after 90. He had a fainting spell from an episode of spontaneous atrial fibrillation. His cardiologist did not believe he warranted anticoagulation. My father was very clear that he wanted me to be his son, not his physician.

One day last October, I returned from a backpacking trip and called my dad to check in. The man on the phone was not my father. The answers to my questions came as halting monosyllables. Something was desperately wrong.

Urgently I arranged to take a week off from work. My wife and I drove up to Ashland.

Dr. Brosbe is a Santa Rosa family physician.

My dad was vacant. My cognitively challenged stepmother had not recognized the change and was very upset that he was not participating in the household chores.

My father looked at me and asked, "What am I to do now?" This became his mantra. I instructed him where to sit and when to eat. It is a humbling experience to bathe your parent. To help him dress. To wipe him after a bowel movement. To buy the dreaded Depends.

When my dad would wander into our room and turn on the light at 2 a.m. and again at 4 a.m., I learned what feelings fuel elder abuse. "Dad, this is a clock," I explained. "Can you see the clock? You cannot come into our room until the clock says six."

I became emotionally and physically exhausted. My stepmother went around the house saying, "You are going to spoil him. He has to do these things by himself."

We arranged placement in a facility that had assisted living and skilled nursing. We chose a place in Danville because it was closest to my stepmother's Walnut Creek son. My stepmother was obviously going to be living there longer than my dad.

We helped them move from their three-bedroom house to a small one-bedroom apartment. Which clothes to take? What pictures? "No, Mom! You do not need to take the toilet brush!" Where was the remote control? I was begging to turn this experience off.

We drove down to Danville. I spent the first few nights with them, sleeping on the couch. I admit to giving my dad sleeping pills so he could sleep through the night without wandering.

He was given physical therapy and assigned a walker. The sign on the walker said, "Ed, use this to walk with."

At first he seemed to rally. My brother flew up, and the three of us played a game of pool together. My father actually had some conversation.

Then things went downhill. My dad started having uncontrolled diarrhea and fecal incontinence. His assigned physician ordered a *C. difficile* test and Immodium. My father had not been in a hospital for over 30 years and had not taken antibiotics for years.

His doctor made it very clear that he did not welcome any input from me. I was beside myself. Dad was deteriorating. Do I take family leave and bring him to live at my house? What about my stepmother? She did not want to deal with his problems, but she did not want him to leave her. Do I become my father's doctor and have him admitted locally to be treated by a trusted colleague?

In the end, we hired a private male caregiver to be with him during the day. We paid for other caregivers to go in at 9 p.m. and help him get ready for bed. I called every evening and tried to reassure him that he would be all right.

One night he suddenly exclaimed, "I'm bleeding! I'm bleeding!" I called the nursing station. No answer, voice mail. They are passing evening medications. They will not be back to check messages for over an hour.

Sure he was having an acute GI bleed, I panicked. On the drive down, I considered my options. Do I take him to a local emergency room? If his vitals are stable, should I bring him back to Santa Rosa to be admitted?

I run from the parking lot. I burst into the room to find my father sitting on the couch, clearly in no distress. "Dad, you said you were bleeding." He holds up his right hand. It has an avulsed skin tear that is still oozing blood. I go to the nursing station and find him a band-aid.

My days of being conflicted are over when his hired caregiver realizes that the nurse has been giving my dad his medications with a glass of milk twice a day. Obviously this had been causing his diarrhea.

Unfortunately, the damage was done. My dad hated being dependent. He felt useless and helpless. He would hardly talk. When he did, he would tell me over and over in his own language, "You had it all set up. You had it right. I ruined it. I ruined it." He was trying to apologize for not being able to participate in the life I had given him.

Grandchildren come to visit. He is delighted to see them. I ask him, "Dad what would you like to do with your grandchildren?" He looks up and says, "Whatever your mother wants to do." "Dad," I answer, "Mom's dead. She died of cancer a long time ago." He looks up, and all he says is "Oh."

In January, at his 92nd birthday party, he watches everyone celebrate. He reaches over to touch the arm of his toddling great grandchild. He does not eat. He has stopped eating. He has willfully stopped eating.

I am at the hospital doing rounds when the call from the paramedic comes. I am crying and shouting into the phone. "Please don't do anything," I beg. "Just keep him comfortable. He does not want CPR." The paramedic assures me that they have seen his DNR form. The nurses are trying not to stare at the crying doctor shouting into the phone.

By the time I get there he is dead, lying on top of his bed, fully dressed. I caress his face. His skin is very white and cold. I give him a kiss goodbye. I watch him being taken into the back of the hearse.

The problem with having an elderly parent is that you mystically assume they will always be there. I think my dad chose to die rather than live and be unable to care for himself.

What if I had brought him home? What if I had admitted him to the hospital? How do you grant yourself forgiveness? When people try to comfort me by saying that he had a good long life, it just sounds hollow.

I should be grateful. He died peacefully. Gently. He would have died eventually, regardless of whatever I might have done.

The forgiveness remains elusive. I crawl into bed at night, always exhausted. I roll over on my right side and repeat, "I'm sorry. I'm sorry. I'm sorry." ◇

Email: Herbert.Brosbe@stjoe.org

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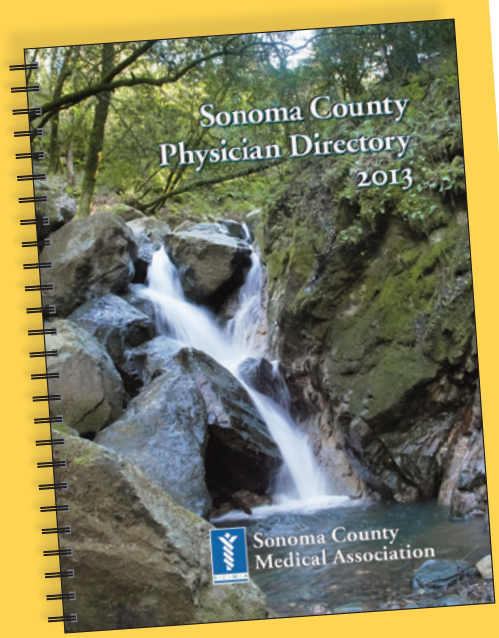

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Volunteering at the Jewish Community Free Clinic

Donna Waldman, MS

In 2001, Dr. Robin Lowitz and a group of committed friends and colleagues founded The Jewish Community Free Clinic in a one-room Cotati clubhouse. This small cohort saw that many people in our community had neither health insurance nor access to quality medical care, and they were determined to address that need. They created a completely free, volunteer-run clinic that provided services once a week on a drop-in basis, the only requirement being a lack of insurance.

In the 12 years since our opening, thousands of uninsured adults and children have received medical care and social services completely free of charge at the JCFC. Today we are located in a permanent facility in Rohnert Park. At our small but well-equipped site, we ensure that neighbors in need have on-demand quality care. Our services are still provided by volunteers, and we completely rely on their support in order to enact our mission. Over the past year, more than 160 local physicians, nurse practitioners, social workers, psychologists, nurses, translators and front-desk staff came to lend a helping hand at our six weekly clinics.

We continue to grow and expand. In addition to primary care and acupuncture, we provide free immunizations and laboratory testing, women's health services, work physicals, and a free dispensary for common medications. Social services are also an important part of our program, and our goal is to refer each client to a community clinic for ongoing care. Our participation in the Redwood Community Health Coalition has enabled us to be true community partners in the process of ensuring quality care to local residents. Getting clients into a permanent medical home at a community clinic has become a principal goal.

As Thomas Dewey wrote, "Students learn best not by reading the Great Books in a closed room but by opening the doors and windows of experience." In our community, both Sonoma State University and Santa Rosa Junior College embrace this Service Learning philosophy, and our partnerships with these educational institutions have allowed us to succeed as a safety net organization. Since 2005, for example, JCFC has provided a training venue for hundreds of family nurse practitioner interns from Sonoma State, and this past semester the university operated two weekly clinics at JCFC.

This partnership has been an ideal opportunity to maximize community resources and give students quality clinical training both from their university preceptors and from experienced JCFC practitioners. What is so unique about the Service Learning experience at the JCFC is that students are able to learn in an environment that inspires sensitivity to the lives of the underserved, providing a true education of the heart.

In addition to SRJC and SSU, we also partner with the Berkeley College of Acupuncture and Chinese Medicine, Touro University School of Medicine, and the Santa Rosa Family Medicine Residency. We join forces with the Redwood Empire Food Bank to provide a food dispensary, and with the Redwood Community Health Coalition to offer Cal-Fresh enrollment services. These partnerships contribute to the core of our model, offering unique educational setting unavailable elsewhere, and giving local physician volunteers the opportunity to share their knowledge.

JCFC operates with a small executive staff. Dr. Deborah Roberts, our clinical director, is also chair of the nursing department at Sonoma State. Her keen understanding of both institutions strengthens our ongoing partnership. Our medical director, Dr. Jerry Connell, practiced locally for close to 40 years, and he brings considerable medical and community experience to his position. Under the leadership of our clinical and medical directors, JCFC is uniquely positioned to provide quality care to our uninsured clients.

Ms. Waldman is executive director of the Jewish Community Free Clinic in Rohnert Park.

Volunteer participation is the fuel that keeps our clinic thriving: without it there is no way to carry out our work. We always need more volunteers, particularly primary care physicians, nurse practitioners and physician assistants. The number of providers available each week determines the number of people who can be seen, so recruiting local volunteers is critical.

Would you be interested in volunteering for the JCFC? You can work as little as one or two shifts a month, and we can design schedules to accommodate your availability. As a volunteer, you can effect change not only in the lives of our patients, but also in the future careers of medical professionals in training. To volunteer, contact us at 707-585-7780 or volunteercoordinator.jcfc@gmail.com; you can also download our volunteer application at www.jewishfreeclinic.com.

Help make this community jewel shine even brighter. Volunteers often report that their time at the JCFC renews their belief in the power of good, and they find the experience to be unusually rewarding. ◇

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SCMA ALLIANCE & FOUNDATION NEWS

Keeping Schools Safe from Bullying

LISA SUGARMAN

"We have seen a dramatic change in the culture on campus. Bullying and harassment is less accepted. It used to be nobody would say no to the negative things going around. Kids today are more concerned about the welfare of other kids and about the potential for violence. Now when kids see other kids not respecting and not helping each other, they say, "Hey, that's not what we do around here."

—Dan Evans, Counselor, Rincon Valley Middle School

IN RECENT YEARS, public awareness of bullying and aggression among school-age children and teens has increased, and the notion of bullying as a normal rite of passage has begun to dissipate. Yet, still too often, we see reports of suicides of young people who were the targets of bullying. Less visible, however, are the 160,000 students who skip school every day because of bullying.

Numerous studies highlight the extent to which bullying can lead to physical injury, social and emotional problems, and even death. Children and adolescents who are bullied are at increased risk for mental health problems, including depression and anxiety. Bullying can also cause long-term damage to self-esteem. Children and adolescents who are themselves bullies are at increased risk for substance use, academic problems, depression and violence later in life.

In response to this problem in our local community, the SCMA Alliance Foundation created the Safe Schools program in 2001 in collaboration with the Sonoma County Office of Education (SCOE). Safe Schools provides grants to local K-12 schools to implement anti-bullying and anti-violence programs. These grants are an essential resource for financially strapped schools to obtain these important and much-needed programs.

SCOE evaluates a wide variety of bullying and violence prevention programs for their effectiveness, and schools use this information to select the program that best suits their individual needs. Programs selected by the schools and funded by the SCMAA Foundation include The Toolbox Project, an anti-cyberbullying club, Second Step, and Safe School Ambassadors.

The SCMAA Foundation awards, on average, $1,000 grants to 10 schools annually. These grants have helped provide training to thousands of students, families and school staff throughout Sonoma County. Money raised for the Safe Schools program comes from the Foundation's annual Garden Tour, as well as through the generosity of individual donors Elly Werner and Leo Hoefer of Santa Rosa.

The collaboration between SCOE and the SCMAA Foundation demonstrates a creative approach to reducing bullying and violence in our schools. Recognizing that there is no one-size-fits-all solution to these complex issues, the Safe Schools program empowers schools to select the individual program that is most likely to create a healthy environment where students feel safe to learn. Sue Simon, principal at Yulupa Elementary in Santa Rosa, said that her school's program, Toolbox, gives "parents, students and staff the ability to speak the same language and problem-solve in very specific ways. For staff and kids it has created a big difference. It has created a kinder, softer place."

Would you like to learn more? Contact the Safe Schools chair, Kathleen Cortez, at safeschools@scmaa.org or visit the SCMA Alliance website at www.scmaa.org. ◇

Ms. Sugarman is a past president of the SCMA Alliance & Foundation.

Anthromyopia

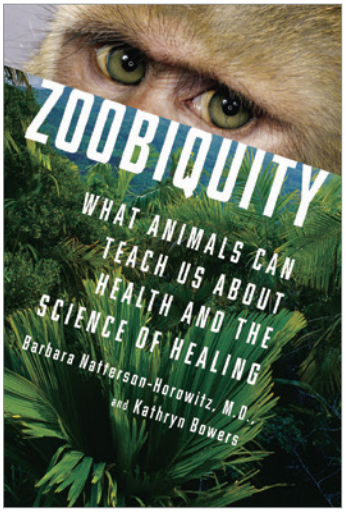
Brien A. Seeley, MD

Zoobiquity: The Astonishing Connection Between Human and Animal Health, Barbara Natterson-Horowitz, MD, and Kathryn Bowers, Vintage, 416 pages.

Someone told me it's all happenin' at the zoo. I do believe it—I do believe it's true.
—Paul Simon, "At the Zoo"

What occurs in nature is inherently justified, and is even viewed by many as divine. The unveiling of what goes on in nature by modern science could therefore be considered to reveal a new kind of scripture, ever unfolding, worthy of some reverence. It might even provide valid answers to the deep questions that Paul Gauguin posed in his painting titled "Where do we come from? What are we? Where are we going?" In biology, Darwin, Mendel, Watson and Crick began this unveiling by elucidating the principles of genetics and evolution.

In their recent book, *Zoobiquity,* coauthors Barbara Natterson-Horowitz, MD, and Kathryn Bowers continue the unveiling as they expand these principles into new revelations about the pervasive connections between human and non-human animal health. The astonishingly close similarities in behaviors and diseases that are evidenced across the entire animal kingdom, and the DNA evidence that back them up, challenge our fundamental concept of a food chain. The reader can no longer think of animals as incapable of emotion, pain, guilt, happiness or pleasure. *Zoobiquity* has powerful ramifications for meat-eaters, slaughterhouses, feed lots, poultry processors and other strongholds of the meat-processing industry.


ZOOBIQUITY
WHAT ANIMALS CAN TEACH US ABOUT HEALTH AND THE SCIENCE OF HEALING
Barbara Natterson-Horowitz, M.D.
and Kathryn Bowers

Natterson-Horowitz is ideally qualified to explore and explain this domain, being both a cardiologist and a psychiatrist. Bowers proves to be an accomplished writer/journalist/punster whose keen wit and interest in the subject much enlivens it. The breezy writing style is a just-right dressing of complex bioscience with vivid lay terminology. The spectrum of medical topics covered ranges from addictive behavior to cancer to yaws, and most are presented with astute observations as to their significance for both our health and our role in the ecological community.

Early in the book, the authors point out the compelling parallels between animal cancers and those of humans. The fact that certain animals are genetically programmed to get certain types of cancer or rarely get other types; that lactation consistently lowers the chance of breast cancer; that some species' die-offs can serve as "canaries in the coal mine" to alert humans to cancer-causing toxic waste impacts—these are all posited as opportunities for physicians, veterinarians and researchers to discover new and better ways to treat the disease. Cancer found in Jurassic creatures suggests the disease may not result from human activity or pollution. Very low cancer rates in whales hint at potentially cancer-resisting genes waiting to be discovered, decoded and harnessed for therapeutic use.

As a main and recurring theme, *Zoobiquity* delights in retelling "the birds and the bees" as seen through the dispassionate lens of medicine. The chapter titled "Roar-gasm" might be better named "Penis Envy Gone Wild." Many pages are devoted to a penetrating look at the diversity and mechanics of animal penises, in a treatise that repeatedly points out the failings of their human counterparts' members as evolutionary hand-me-downs from the animal kingdom. This discussion fathoms the depths of penile dysfunction in animals as having the same complex of causes, both emotional and hydraulic, as those in humans. The clinical tone that the authors apply to the discussion is more than enough to make virgins blush and macho males soften their strut.

A seeming fascination with animal sexuality and the evidence supporting the likelihood that animals actually derive pleasure from sex pervades these discussions. The evidence includes examples of animal foreplay, masturbation, bi- and homosexuality, oral sex, rape, bestiality and pedophilia. They describe a finding that nymphomania in animals, as in humans, is often accompanied by masculinizing effects that result from testosterone secreting tissue in polycystic ovaries. The authors also emphasize the shocking truth that all animal sex

Dr. Seeley, a Santa Rosa ophthalmologist, serves on the SCMA Editorial Board.

is "unprotected" and muse on how this might actually confer advantages in the germ-dominated world of STDs.

The account of animals' behavior goes beyond their libidos to encompass their addictions, eating disorders, suicides and self-injury (cutting)—and these too are found to be disarmingly human-like. The effect is to reduce the stigma for those behaviors in humans. In fact, the behavioral parallels are so close and comprehensive across the animal kingdom that Darwin doubters are effectively chased away, tails between their legs; but the authors take some care not to dwell on this issue. Likewise, although their book pierces the thin veneer of civilization, they are clearly not embracing a morality based solely on behaviors found in nature. "Often," they write, "what's endearing in animals is detestable in humans. So while we may chuckle at the intoxicated Tasmanian wallabies, we'd be justly horrified if they were Tasmanian children with a heroin habit."

"Zoophoria" is the title of a chapter devoted to the pleasure of reward and its powerful influence on animal behavior. Both OCD and drug use are shown to be pervasive in animals, and the authors seek to explain why. Natterson-Horowitz confesses to having held a previous view that applying the term "addiction" to behaviors was merely a "no-fault, feel-good cop-out, a lazy, twentieth century inability to break bad habits." But after her awakening to the veterinary perspective on the ubiquity of substance and behavioral addiction in the animal kingdom, she admits that these are driven by a shared neurocircuitry that rewards them as survival and fitness-promoting behaviors. As examples, she cites the behaviors of seeking sexual pleasure, binge eating, exercise highs and even compulsive gambling, which she interprets as foraging taken to an extreme. Survival advantage is repeatedly cited by the authors as the underlying, all-natural reason for why animals do what they do.

The animal world is replete with examples of how sensory perception and emotion in animals can simultaneously alter both their behavior and vital signs. Natterson-Horowitz draws close analogies between these and the sudden heart slowing or stoppage in humans, and she shows a thoroughgoing understanding of the important interactions of feeling and physiology. She raises the possibility that SIDS could be caused by the fright of sudden loud noises heard by an infant who feels trapped in too-tight swaddling. This mind-body connection inescapably leads us to reexamine the ethical issues inherent in our treatment of all animals. The long-held Cartesian view that consciousness is necessary in order to feel emotion or pain is discarded in recognition of the pervasive, clearly important role of feelings in the survival circuitry of all animals.

Zoobiquity is well named, for it contains a comprehensive array of significant examples of how our human health issues are shared by animals—the issues truly do seem to exist everywhere. Though too numerous to catalog here, some fascinating examples are worth mentioning. For example, the parasitic worm that hijacks the grasshopper's brain—thereby putting the grasshopper on a suicidal path in order to ensure its own worm life-cycle—shows that diabolical advocacy is not a human invention. Koalas get chlamydia because they don't use condoms. Dragonflies get obese due to particular types of gut flora. Rats giggle inaudibly when their bellies are tickled, and they moan when in pain. Pigs get anorexia due to stress and, like humans so afflicted, show incessant movement and cessation of estrus. Adolescent animals, like human teenagers, show the too-familiar thrill-seeking, reckless behaviors that mellow with age.

Natterson-Horowitz and Bowers have done a wonderful job of showing how greater understanding of animals of all kinds could help us find new and better treatments for human and non-human animals alike. Yet one gets the clear impression that we have only clawed the surface of the insights to be had. The overall effect is to multiply our wonder at the world of nature and its eons-old influence upon humankind, while diminishing our respect for the "Johnny come lately" status of our human-contrived definitions of what is "natural," proper and healthy. The reader will likely be imbued with a greater affinity for birds, insects, squirrels, horses and pets, and a greater respect for their rightful places on Earth. ◇

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Health Reform Heats Up

James Noonan

President Obama signing the Affordable Care Act in 2010.

More than three years have passed since the Affordable Care Act (ACA) was signed into law, setting into motion some of the most dynamic and volatile years the nation's healthcare industry has ever seen.

Since its inception, the ACA has been a subject of controversy, inspiring hotly contested debates across the entire nation. For some, this dramatic overhaul of the country's healthcare system represents our national leaders finally making good on the long-overdue promise of "healthcare for all." Others claim that the law is a clear overreach of federal authority that threatens to overburden an already fragile economy.

Although the law remains controversial, the United States Supreme Court has ruled that it is constitutional, and active steps are being taken to move forward at the federal and state level. The vast majority of activity is yet to come. With many of the provisions set to take effect next January, state officials across the nation are scrambling to make sure they're ready to implement the law's sweeping changes.

The road has already been somewhat rocky. Throughout the implementation process, the U.S. Department of Health and Human Services has been narrowly meeting its own deadlines, oftentimes leaving states waiting for federal guidance that could dramatically alter their own implementation plans. With several major deadlines coming in the next few months, many observers expect this problem to only get worse.

Adding to the headache for the federal government is the mixed support that the ACA has received from the states. To date, only 17 states and the District of Columbia have elected to develop their own state-run "health insurance exchange" (also called "health benefit exchange"), an online marketplace where consumers can purchase subsidized coverage. An additional seven states will form state-federal partnerships to operate their marketplaces, while the remaining 26 states have declined to participate, meaning the federal government will be responsible for operating exchanges in those areas.

The next major milestone toward full implementation of the ACA is set to take place on Oct. 1, when the health insurance exchanges are set to begin their pre-enrollment. In the first years following these marketplaces going live, more than 32 million currently uninsured Americans are expected to gain coverage, either through an exchange plan or the ACA's massive expansion of the Medicaid program. Some analysts expect as many as 5 million of these newly insured patients to come from California.

On Jan. 1, 2014—three months after pre-enrollment begins—the exchanges are set to go live, meaning that millions of Americans will, for the first time, be able to purchase coverage using the federal subsidies promised in the ACA.

In order to navigate this massive undertaking, states will need to decide which plans will be offered through their exchanges and construct the actual online marketplaces through which consumers will purchase coverage. They will also need to implement major public outreach campaigns to ensure that these citizens—many of whom have never had the benefit of "open enrollment" or a similar purchasing period—understand how and where they can sign up for coverage under the reform law.

These tasks are daunting on their own, but with a deadline looming only months away, skeptics could be forgiven for questioning whether completing them is even possible.

Mr. Noonan is a staff writer for the California Medical Association.

Despite the uncertainty swirling around the ACA's implementation, California looks to be on track to meet the coming deadlines. In the days following the ACA's passage, California was the first state to establish a health benefit exchange (Utah and Massachusetts were operating their own versions of an exchange before the ACA was signed into law) and has been working toward implementation ever since. That exchange, named Covered California, has already launched its online consumer marketplace, www.coveredca.com, and is one of 25 states that have gained conditional approval from the federal government to operate its own insurance marketplace.

Unfortunately several recent decisions by the exchange board have placed California's physician community on its heels. The California Medical Association (CMA) has been an active participant in stakeholder hearings and is working to ensure that the interests of physicians and their patients are taken into consideration as the exchange prepares to open for business.

Several issues of concern arose when the board was working to finalize the benefit standards that interested payors will be required to meet in order to have their products considered for the Qualified Health Plan (QHP) designation. One major concern for physicians is how the exchange will deal with monitoring and ensuring network adequacy among QHPs.

Throughout the benefit design conversation, exchange staff continued to favor the existing method of network monitoring, which calls for the Department of Managed Health Care (DMHC) and Department of Insurance (DOI) to be responsible for ensuring that plans offered to consumers have enough participating providers. In other words, the status quo. Several stakeholders, including CMA, have noted that those two entities are currently unable to ensure adequate networks among existing plans and would likely be overwhelmed by the added task of monitoring additional exchange products. While CMA asked that the exchange take an active role in monitoring networks beginning in 2014, the DMHC/DOI method remained in the final benefit standards adopted by Covered California's board of directors, meaning it could become the norm once the state's marketplace goes live.

CMA also voiced concern over the exchange's handling of the "grace period" provision included in the ACA. Under current California law, patients who are delinquent on their premiums are allowed a full 90 days to settle up before their policy is terminated for nonpayment. However, under the ACA's grace period provisions, exchange plans will be allowed to suspend payment for services rendered if an enrollee is more than one month delinquent. If the patient fails to settle up within the three-month grace period, the plan can then terminate coverage for nonpayment and deny all pending claims for services. In this scenario, physicians could potentially be on the hook for 60 days worth of services with no avenue for recourse.

CMA has repeatedly asked Covered California's board to reconcile the state and federal policies, but to date an adequate fix has not been presented.

Given the exchange's accelerated timeline, as well as the exchange board's tendency to revisit issues that were previously thought to be decided, it remains possible that both of these matters, along with others that have caused concern to physicians, could see some sort of resolution before 2014.

To be sure, the next few months will be some of the most important and tumultuous times the medical community has faced in recent memory, but as a CMA member you have the comfort of knowing that your interests are being advocated for in front of all the key players driving the nation's reform efforts. ◇

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* = board certified
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Linda

J. Michael Gospe, MD

Since I retired from my practice of gastroenterology and internal medicine 14 years ago, I have held the part-time position of director of medical ethics at Memorial Hospital. One morning between meetings, I went to the physician's lounge for a quick cup of hot chocolate. As I passed a computer screen, a name that triggered forgotten memories met my eye. Three words unconsciously poured out of my mouth, "That's my patient!"

I hadn't thought about Linda since I retired, but at that instant I saw her face in front of me. Her history flashed into my consciousness like a raging river. A swirl of numerous office and hospital visits where we confronted the twisting curves of her symptoms inundated my mind. Long-forgotten feelings about this young woman filled my heart: sadness, frustration, even fear of making mistakes in her treatment.

When Linda (not her real name) first entered my office, she was a sweet young woman barely out of her teens. I was in my early 30s, in the midst of developing my practice and raising a family. She was one of my first challenges, a challenge that continued well over 20 years.

During the extended period of our relationship, I treated her for a multitude of complications from Crohn's disease, a type of inflammatory bowel disease. Some people seem to repel illness. Linda was like a sponge and soaked in disaster after disaster, building a thick patina of disease around her frail body. Just when I thought that things couldn't get worse, they did. Linda faced this life day after day, year after year.

I was gratified as she learned how to adjust her prednisone doses in anticipation of flare-ups. The two of us learned how to balance on a tightrope, discovering how thin the line was between the side effects of too much medication and control of her disease.

Although Linda generally came to the office with a smile, it didn't take a psychic to see that she also wore a gown made of sorrow, fear and pain. I felt impotent every time she developed another complication that sent her to the hospital. An endless litany of surgical procedures eventually left her without a colon. She also endured the loss of a portion of her small bowel, the removal of her entire stomach, and the elimination of her gall bladder. In addition, she had the discomfort and disability of rheumatoid arthritis.

After seeing my former patient's name on the screen, I spoke to her physician. When I found out Linda was 53 years old, I couldn't believe it; in my mind's eye she could not be older than her mid-30s. There was no way that the young woman of my memories was 53.

After I discussed the case with Linda's physician, I went to a meeting, but I could not erase thoughts about Linda from my mind. Immediately after the meeting, I raced to the second floor of the hospital and entered the ICU. My heart sank when the sight of a frail cachectic woman met my eyes. Multiple intravenous lines entered her arms, and a tube connected her lungs to a respirator.

My mind accepted Linda's condition; after all, I had seen many patients looking far worse in my years of practice. However, my psyche overpowered my mind as it jumped back more than a decade to a time when I felt the same grief. That was when my wife and I saw our oldest son in the recovery room after undergoing a tonsillectomy. Internship and residency did not prepare me for the sight of our baby boy spread-eagled in bed, sedated, impaled with tubes and needles. I was not prepared to see Linda look like this either.

Linda had suffered a massive intestinal hemorrhage from multiple ulcers in her small intestine. She also had respiratory failure from pneumonia and could not breathe on her own. Yet, her emaciated face still retained the clear likeness of the young woman I had known so long ago. I had a need to let her know that I was there and had not forgotten her. I wanted her to know she was not alone in this battle. Although she opened her eyes when I spoke her name, I'm certain she did not recognize me.

I reviewed her chart on a daily basis and returned to the unit several more times during the week, hoping to find an improvement in her condition, hoping to be able to communicate with her, to tell her I cared. Linda never recognized me. She died quietly less than a week after I learned she was in the hospital. I will never forget her. ◇

Dr. Gospe is a retired Santa Rosa gastroenterologist.

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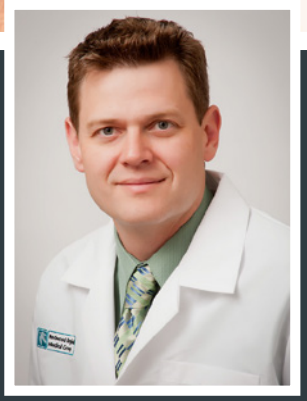

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